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NEW TASKS OF THE SOCIAL WORKER CREATED BY NEW DRUG THERAPY*

BY FRANZI WEISS, M.S.S.

"Tranquilizing," or ataractic or phrenopraxic drugs have, as is well known, led to a great increase in releases from mental hospitals.

Not only the *numbers,* but also the *kinds* of patients who can be considered for release have changed. In the past, psychiatric social workers mostly received referrals, for casework and convalescent care studies, of patients who had suffered from acute mental illnesses. They hardly ever saw patients who had been continuously hospitalized for more than three years. Now they get numerous referrals of chronic schizophrenics who have been hospitalized up to 10 years or even more. This creates new problems for the patient; and these are in the process of being identified. New ways will have to be found to deal with these problems to enable the patient to keep his adjustment after his release in the community. While all patients *should* have social service, patients on chemotherapy, *must* have social service contact around the time of release.

How Does One Plan for the Chronic Patient?

How do we plan with patients whose relatives have not shown any interest during their hospitalization? While we unfortunately also have acutely ill patients whose families do not care for them, or actually ill patients who have no families, this problem becomes increased by long hospitalization.

The long hospitalization of a chronic patient brings many changes in the family constellation and in the family's attitude toward the patient. Feelings of guilt and anxiety about the patient become intensified.

When social workers approach these families, they find that the members have moved away or that the marital partner has remarried. The patient's children may have been placed in foster homes where they have learned to regard their foster-parents as their real parents; the patient's own parents may have died or

*From the Manhattan Aftercare Clinic special follow-up study of patients treated with thorazine. Read at the New York State Welfare Conference, New York City, December 12, 1956.

grown too old to help the patient. A family may say that the patient cannot be taken back into the home because by now the whole neighborhood knows that "he had been put away," and nobody would visit the house if the patient were to live in it.

The social workers will, of course, also find families who will be willing to accept the released patients; but, in working with them, one must be aware of their own insecurities about how to treat the patients and of the pressures which their neighborhoods may put on them.

Most chronic patients who have received drug therapy will have to receive maintenance dosage for a very long time, maybe all their lives, like diabetics who have to take insulin permanently. Interpretation of this need and discussion of how the patient can get the needed drugs are indispensable in convalescent care study.

The patient who will not be able to go back to his family will need the social worker to help him prepare for a new and strange life situation. The patient who has been hospitalized for many years has become much more dependent than the acutely ill patient, and the social worker will have to recognize that *he* is the person who must meet the dependency needs when the patient finds himself alone in a new world without anybody to lean on. Suddenly he has to make decisions for himself and carry a lot of responsibility, such as he has not carried for many years.

The social worker should, therefore, extend help *immediately* after release. Apart from the psychological difficulties in making a new adjustment and getting weaned from the hospital environment, many crucial matters which could not be foreseen may arise during the first week on convalescent care.

Some of these difficulties will be illustrated with case material from New York state hospitals serving the metropolitan area. The writer would like to stress than no pre-convalescent studies had been requested in any of these cases and that she, personally, feels that these difficulties would not have arisen, had there been a social worker engaged on any of the cases in the hospital.

Anne W., a 47-year-old woman, diagnosed dementia praecox, paranoid type, had been hospitalized for 10 years. During her hospitalization her only daughter died. She had been separated from her husband for a long time before admission. She had a sister who lived with one daughter and also had lost a daughter recently. The patient had responded very well to chlorpromazine

and was released to the custody of her sister. She was to be continued on a maintenance dosage of the drug and, since she was referred to the thorazine unit at the Manhattan Aftercare Clinic, she was seen there on the day following her release from the hospital. The patient made a very good impression during her first interview and immediately asked the social worker whether she could help her sister. The sister was interviewed and found upset, ashamed and guilty. She said that she could not take the patient into her home. The landlord would evict her; her daughter could not be visited by friends, and so on. Another plan had to be worked out immediately. In a joint conference with the patient and her sister, it was agreed that the patient would move in with a friend who seemed to be understanding and able to take the patient to her house if the Department of Welfare could provide public assistance.

The patient has now been outside the hospital for 14 months. She continues on thorazine, works, lives by herself and visits her sister who could relate better to her as soon as she was relieved of the responsibility of caring for her.

Another case illustrates how poor initial planning cannot always be counteracted. Irma S. had to be returned to the hospital after five months on convalescent care in spite of the fact that she had close medical supervision and was maintained on thorazine. Without the drug and the frequent clinic contacts she might have been back at the hospital much sooner.

A 56-year-old woman, one and one-half years in the hospital, diagnosed manic-depressive psychosis, manic type, she was released to the custody of her sons. During the ride from the hospital to their home, she was informed of the following new facts in her life: (1) that one of her sons had gotten married two weeks previous to her release; (2) that both sons and the daughter-in-law had moved to a new apartment in a new neighborhood and that she was expected to live with them (previously her sons had lived *with her* in *her* place); (3) that her own apartment had been given up; and (4) that all her furniture and dishes which she had owned for 30 years had been discarded and that her sons had gone into debt to provide the new home which she was to regard also as her home.

When the patient related all this during her first interview, she was in good contact but understandably deeply upset. Thora-

zine was immediately increased; and she received supportive therapy and was seen frequently, but the damage had been done at the outset, and she could not be maintained in the community.

Can We Expect Perfect Patients?

In a recent lecture, Kubie* stated that most therapies, including psychotherapy and drug therapy, leave patients—and he did not refer only to the mentally ill—"half cured." He felt that these half-cures create many new problems and illustrated this with the case of a mentally-ill mother who, had it not been for tranquilizing drugs, would never have been released from the mental hospital. However, her basic hostile suspicious personality had not been changed, and her harshness was damaging her children who had previously been cared for by a warm motherly person.

This brings up some thoughts about how the tranquilizing drugs help. What do they affect? The writer does not believe that they affect the basic personality structure. What is affected seems to be the patient's daily functioning. The anxiety which was so overwhelming that the patient had to break with reality and develop psychotic symptoms is reduced. The patient's conflicts still exist, but the patient can look at them more objectively and so solve them better. Social work techniques, therefore, should be on the supportive level. The patient should be permitted to depend on the worker to meet his dependency needs. At the same time he should be helped—by clarification of his problems—to come to decisions which will eventually make him independent. The anxiety-reducing drug is the great ally in attaining this goal.

The writer had a case very much like the one described by Dr. Kubie, but a satisfactory solution was found, through regular casework contact, plus a maintenance dosage of reserpine, which made it possible for the patient to cope with her very difficult situation.

Ida I., a 28-year-old, attractive, married woman, mother of three children, nine, eight and six, had been hospitalized for five years—diagnosed dementia praecox, mixed type. For years, she had not responded to any form of treatment until reserpine had helped

*Kubie, L. S.: The fundamental nature of the distinction between normality and neurosis. Paper presented at the clinical staff meeting at Rockland State Hospital, November 14, 1956.

her to leave the hospital. She was described as a gentle, cheerful person who had always been slightly withdrawn.

Her husband had been left with the three children and an apartment in a housing project; and he had made every attempt to keep the family together. Had the hospitalization been a short one he would have been able to manage with the help of the patient's mother and the day care center nearby.

The illness took too long, however, and the husband accepted the help of a woman who worked in his office. She was described by the day care center as a motherly, outgoing woman, who was a much better housewife than the patient. She was childless, had always wanted children and found so much satisfaction in her role as a substitute for wife and mother that she left her own husband and moved in with the family.

The patient's release brought more heartache than joy. She found herself competing for the love of her husband and children with a person unknown to her. The children's teachers were anxious about the situation and brought the social worker in at once when the patient was released. The other woman moved out, but the children spoke of her constantly.

While the patient's basic personality had not changed, the maintenance dosage of serpasil made her almost serene. She was no longer withdrawn and was helped to discuss the situation frankly with her husband and her worker. She insisted on meeting the other woman and was able to control her inner resentment and hostility during this meeting. She made the children comfortable when they mentioned the other woman. She learned to do her household chores better and to respond to the children's needs. The most difficult problem was the husband's attitude, but the worker was able to establish a relationship with him and appreciate his needs. He responded by becoming more accepting toward his wife. The patient has now been outside the hospital a year and a half. The children continue their good adjustment.

It is felt that the serpasil alone could not have done this; but, without the serpasil, the patient would have been much too anxious to participate in the solution of her problem as actively as she did.

There are many other things one must become aware of, and sensitive to, with patients who have lived for several years so far from ordinary life. The cost of living is higher; their clothes

have gone out of fashion. When a patient receives a budget letter, he may think the welfare allowance will be ample. He would like to buy a lot of new clothes, then finds that the welfare checks barely cover his essential needs. It is the worker's task to help a patient stay within the budget and to orient him toward new steps of rehabilitation, so that his life can become more satisfactory to him.

What Answers Are Needed?

What equipment is needed to answer direct questions about tranquilizing drugs? The writer feels the need is for information above all. Social workers are not medical doctors and, therefore, cannot prescribe medication or change dosage; but social workers should know enough to recognize when medication or a change of dosage is indicated so that they can bring it to the attention of the doctor. Dosage has to be determined *individually* and varied according to the increasing or decreasing stress to which the patient may be submitted. Because of the interaction between stress-situation and dosage, it is more than ever necessary that doctor and social worker confer constantly and work as a team.

The doctor's knowledge of the patient's activities may also help to determine at what hour and in what strength the drug should be administered. For instance, a housewife without children, who can afford to rest during the day, can take a higher dosage in the morning than a painter, who spends his day on a ladder where drowsiness may lead to accidents.

The more he knows about effects, side effects, and the general results of studying patients under chemotherapy, the better the worker will be able to draw the doctor's attention to unusual reactions. The worker should know what combination of drugs should be avoided and under what circumstances the intake of drugs might have to be interrupted. This will not only be helpful to the doctor, but also to the patient and his family, who constantly ask pertinent questions which the worker should be equipped to answer.

During a recent symposium, Denber* declared: "The psychiatric social workers in this scheme of things will extend their horizons and become the visiting nurses of psychiatry. They will see the patient during the period when the physician is *not* in attend-

*Denber, Herman C. B.: In symposium, "Chlorpromazine and Mental Health." Philadelphia. June 6, 1955.

ance. Psychiatric social workers must extend their fields of activity under psychiatric supervision far beyond any present arrangement."

The writer thinks social workers had better examine their own attitudes and reactions to such a statement. Caseworkers have been known to say: "We don't want to become pill pushers." And doctors have not felt too happy at the idea of letting social workers push pills. The writer feels, however, that the more knowledge workers accumulate about the new drugs and how they help people, the more easily they will change their own attitudes. People would not be human if they were not sometimes skeptical about how much help we can expect from a pill in severe mental illness of long standing. Nobody asserts that any drug is a cure-all; but the "tranquilizers" seem to the writer to be among the more effective tools in the fight against mental illness. The more that is understood about their effectiveness and about their limitations, the more conviction will workers bring to their patients.

The mental hospital release rate has greatly increased; the return rate is still too high. To decrease the rate of returns, there must be both a more effective aftercare program and more and better facilities for released patients in the community. The more patients who can be released from mental hospitals, the more community resources will be needed. Who will be better able to interpret the needs to the community than social workers? As Kris* said in a paper on the social factors involved in the adjustment of mental patients: "If we do not dedicate our efforts in this direction, all the modern treatments within the hospitals will only be work left half undone."

What Are Our Needs?

Thus modern drug therapy should be another incentive for the building of new, more meaningful programs. Here are only a few ideas:

1. Our family-care homes should be smaller and better integrated in the community to give patients a feeling of being part of the family and of the community.

2. Special homes are needed for teen-agers in transition to com-

*Kris, Else B., and Carmichael, Donald M.: Follow-up study on patients treated with thorazine, preliminary report, read at the downstate interhospital conference, New York State Psychiatric Institute, April 2, 1956.

munity life. They could be apprentice homes, which, during the day, could be used as vocational training centers and, at night, as recreation centers, thus providing the teen-ager, whose home is inadequate, with satisfaction of his most basic needs—work and play.

3. We need more and better sheltered workshops. Rehabilitation should both help refresh old skills and encourage the acquisition of new ones.

4. Above all, we need different kinds of old-age homes. Many of our old people respond well to drug therapy and would not have to be hospitalized if we only had better facilities for them.

Settel* remarked in discussing the treatment of senile patients: "Because of the success of 'Thorazine' in the treatment of senile agitation, the autumn years of life for the disturbed senile may conceivably become years of peace and usefulness instead of hopelessness and dependence."

The case of Mary F. illustrates this need. She is a 70-year-old woman who spent three years in a mental hospital, diagnosed dementia praecox, paranoid type. She responded well to thorazine and could have been released after two years had it been possible to find a place for her. Her main difficulty had always involved interpersonal relationships. She had been living with her married daughter and grandchildren in a crowded apartment and had caused serious upsets in the family equilibrium. She could not be returned to her family. Finally a rooming house was found where she stayed for a few months; but her food was "stolen" from the community refrigerator, and she seemed to get into arguments constantly. She found another room, and at first got along well with the landlady who was of her age and cultural background; but, after three months they were no longer on speaking terms. Some attempts were made to get her into an old-age home; but she did not like the idea, because she functions very well, can take care of herself, can cook, shop and clean, and hates the thought of being crowded together with other old women. Also, the social workers, together with the psychiatrist, came to the conclusion that living in close proximity with many women, would only play into her paranoid tendencies and would put so much strain upon her that she would not be able to stay out of the hospital. The

*Settel, E.: Chlorpromazine in the treatment of senile agitation. American Academy of General Practice. Vol. XII, No. 6, pp. 74-6. Kansas City, December 1955.

final recommendation was to find a little apartment and to let her live by herself. She is very well able to enter into superficially friendly relationships. She always found people to talk to in parks and stores, but she needed her privacy at home.

This woman points up the need for public low-income housing for old people. It would be very beneficial to have whole buildings within city projects dedicated to such units. A social worker should be available to see how these old people are doing, and she should also encourage some recreation programs. Apart from that, old people should remain part of the community. They could mingle with other tenants and children on the grounds. In some cases, they could be helpful to overburdened mothers and get the feeling of being useful, needed and less isolated.

How Can the Community Help Supply "Tranquilizers?"

In addition to many new programs, a great deal of co-operation will be needed from existing community agencies. Social service cannot supply the medication for maintenance dosages of tranquilizers, but the patient must be continued on the medicine in most cases. This medication is costly; and, although there has been very fine co-operation by the welfare authorities, there is a very difficult problem when a family is not on welfare but has a "low middle-class" income. An attempt is being made to send patients in this income group to general hospital clinics; and it is hoped that the "tranquilizers" will be given out eventually on the same basis as insulin or dilantin.

The writer feels that if we all work together, we will be able to make the tranquilizing drugs much more effective than they have proved to be so far.

What Are Areas for Discussion?

Some areas for discussion should be highlighted.

This paper deals only with patients who have received tranquilizing drugs, either as residents of a mental hospital or, following hospitalization in a mental hospital, in the community. (Some discussion could well center around people who are treated with tranquilizers without ever having had psychotic episodes.)

As far as hospitalized chronic patients are concerned, these drugs made it possible for many to be released who otherwise would never have a chance to live on the outside. This group

creates more new tasks for the social worker than do patients who have had acute mental illness. The formerly chronic patients will, in all probability, have to receive maintenance dosages for indefinite periods. How can the drugs be made available to them?

How Can Needs Be Interpreted?

How can one best interpret to the patient and the family the need for getting and taking the drug prescribed?

Dosage must be regulated on an individual basis—increased in a stress situation and decreased when the stress situation is over—side effects may also necessitate change of dosage. Therefore, close teamwork between social worker and psychiatrist, and close medical supervision are necessary for all patients who receive tranquilizing drugs. It should be noted here that tranquilizing drugs reduce anxiety and, therefore, enable the patient to involve himself more constructively in the casework process.

How Can Workers Recognize Symptoms?

How can social workers become equipped to recognize symptoms which should be immediately brought to the attention of a doctor? Or how can they become equipped to make emergency decisions when there is no doctor available? Dr. Denber's suggestions that the workers become visiting nurses of psychiatry are pertinent here.

With more patients being released from mental hospitals who can be helped to stay in the community even if they are not completely recovered, today's great social work problem is: How can agencies best enlarge their facilities and programs to meet their needs?

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PSYCHIATRY'S CONTRIBUTIONS TO CRIMINAL LAW AND PROCEDURE*

BY WINFRED OVERHOLSER, M.D., Sc.D., L.H.D.

For over 600 years, the defense of "madness" or "lunacy" or "insanity" existing at the time of the act has been available in criminal cases. Thus it was recognized very early in the English law that mental derangement could exist, of such degree and kind, as to negate the guilty intent without which an act could not be considered a crime. As was to be expected, the criteria of "madness" depended very largely upon the psychological concepts in vogue at the time the various definitions were laid down, whether those might be related to the influence of the moon or to the later "faculty psychology."

In general it was the most marked cases of mental alienation which were considered to justify a finding of lack of responsibility; only the "raving maniac" was likely to be recognized as deranged. Bracton,[1] one of the earliest writers on this topic, said in the thirteenth century, "A mad man is one who does not know what he is doing, who lacks in mind and reason, and who is not far removed from the brutes." Thus we see the knowledge test laid down early, as well as the "wild beast" doctrine, which has cropped up from time to time later on.** Lord Coke, writing in the seventeenth century, followed Bracton to a considerable extent, but pointed out clearly that there was no one test of irresponsibility and that the law must rest upon the general principle of requiring a guilty intent. An insane person, he held, is incapable of having such a criminal intent.

His consistency was not followed by Lord Hale, writing shortly thereafter. In discussing dementia, Hale spoke of "partial insanity," that is, partial as to subjects or things and partial as to degree. "Partial insanity," he said, "does not excuse persons in capital offenses, since most persons that are felons of themselves and others are under a degree of partial insanity when they commit these offenses." He added, "It is very difficult to define the indivisible line that divides perfect and partial insanity; but

*From Saint Elizabeths Hospital, Washington, D.C. Address before Institute of Forensic Psychiatry, Hudson River State Hospital, Poughkeepsie, N.Y., May 21, 1957.

**For a detailed study of the history of tests, see Glueck, Ref. 1. For discussion of criminal intent in relation to mental disease, see Diamond, also Ref. 1.

it must rest upon circumstances duly to be weighed and considered both by the judge and jury, lest on the one side there be a kind of inhumanity towards the defects of human nature, or on the other side too great an indulgence given to great crimes." Hale thus recognized that it is the jury's attitude, despite "tests," that determines the verdict.

Hawkins, a later commentator, writing in the eighteenth century, injected the right and wrong concept in these words: "Those who are under a natural disability of distinguishing between good and evil, as infants under the age of discretion, idiots and lunatics, are not punishable by any criminal prosecution whatsoever." We may date from this period the doctrine of the knowledge of right and wrong which has assumed such an undue importance in the courts since then. From here on, too, the development of the concept of insanity as related to criminal responsibility took place through the medium of case, or judge-made, law. As Wharton and Stille remark, "This is not in any concert, but individually, each judge stating his own concept of the law and his own definition of insanity, there has thus arisen confusion, even contradiction."

Erskine, in the Hadfield case, in 1800, introduced the doctrine that delusion connected with the criminal act must be present, a thesis which we find repeated in the McNaghten Rules. The trend, however, in the English law seems to have been toward greater leniency and humanity until the opinion of the judges in the case of McNaghten was enunciated in 1843. (10 Cl. & F 154.)

McNaghten Rules

Few judicial statements indeed have ever carried such weight, or carried it for so long a period as that of the judges who pronounced the famous "rules" that were formulated because of the case of Daniel McNaghten. McNaghten had been found "not guilty" of murder on the ground of insanity. The testimony made a tremendous impression on the members of the House of Lords who put a series of questions to the 15 judges of England concerning insanity as a defense. The judges' answers, agreed upon by 14 of the 15, are the famous McNaghten Rules. Space does not permit a lengthy discussion of these rules here, even though it is a fact that they are embodied in one form or another in the rulings, and in some instances the legislation (in Sec. 1120, for

example, of the Penal Law of New York!), of practically all of the American states.

Probably the best-known statement in the judges' answers is to the effect that to establish a defense on the ground of insanity, it must be proved that the person accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong. Thus the knowledge of right and wrong was applied to the particular act charged, not (as formerly in the English law) to right and wrong in general.

The judges, it should be noted, added that the instruction should be accompanied with "such observations and explanations as the circumstances of each case require." There was reference in the answers to persons "who labor under such partial delusions only and are not in other respects insane," while the astonishing proposition is also laid down that a delusion excuses an act, provided the situation assumed by the delusion would excuse the act if that situation were a fact. This latter provision provoked from the Supreme Court of New Hampshire in the case of State vs. Jones the comment, "It is probable that no ingenuous student of the law ever read it for the first time without being shocked by its exquisite inhumanity. It practically holds a man confessed to be insane accountable for the exercise of the reason, judgment and controlling mental power that is required of a man in perfect health." We see in the answers strong evidence of the "faculty psychology" which then prevailed in England—one of the echoes of the phrenology vogue, with its belief in independent mental faculties.

The McNaghten Rules, then, set up a solely cognitive criterion in a vain attempt to distinguish between the black of insanity and the white of sanity. No such thing as a borderline condition was recognized.

It should not be thought that the criticisms of the McNaghten Rules are recent only. In Volume 1 of the *American Journal of Insanity* (1844), a writer* commented that the answers "left the jurisprudence of insanity about where it was left by Blackstone and Lord Coke," and indeed, in the very year of the McNaghten decision, another English court, quoting Dr. Isaac Ray, pointed

*C. B. Coventry (P. 134).

out that a rule for the definition of insanity is "chimerical from the very nature of things. The fact of insanity's existence," said the court, "is never established by a single diagnostic symptom."[2]

Irresistible Impulse

The American courts, particularly in the pioneer states, pursued a more logical course, recognizing that there is a volitional as well as a cognitive element in an act. As a result the "irresistible impulse" doctrine was born, being first enunciated in Ohio in 1834. As first stated, "if the defendant were in a state of mind in which at the time of the deed he was free to forebear, or to do the act, he is responsible as a sane man." Soon after, in another Ohio case, the more succinct question was asked, "Was the accused a free agent in forming the purpose to kill?"[3] At present about 17 of the states recognize the "impulse" test in addition to the "right and wrong" test.

Fortunately, however, not all judges have been bound by either the McNaghten or the impulse "test." The Supreme Court of New Hampshire, in the Pike (1870) and Jones (1871) cases,[4] largely under the influence of Isaac Ray's significant writings, threw over all so-called "tests," declaring that whether any alleged criminal act was the outgrowth of mental disease was a question not of law but of fact for the jury. The court concluded its decision thus: "We have consented to receive those facts of science as developed and ascertained by the researches and observations of our own day instead of adhering blindly to dogmas which were accepted as facts of science and erroneously promulgated as principles of law 50 or 100 years ago. ... Enough has already been said as to the use of symptoms, phases or manifestations of mental disease as legal tests of capacity to entertain a criminal intent. They are all clearly matters of evidence, to be weighed by the jury upon the question whether the act was the offspring of insanity; if it was, a criminal intent did not produce it; if it was not, a criminal intent did produce it and it was crime." Alabama, in the Parsons case,[5] followed a similar course of reasoning 15 years later.

In a few instances other modifications had been made, such as a recognition of "moral insanity" and the notion that the feebleness of mind or will might reduce the grade of an offense. This was held, for example, in the Moran case in New York in 1930,[6]

and thus extended the principle of intoxication and heat of blood as interfering with the ordinary operation of the defendant's mind. The Scottish doctrine of diminished responsibility[7] might be mentioned here, too, although interestingly enough it is still unique in the whole English-speaking world. The disadvantage of reducing the degree of crime by reason of mental impairment is that although punishment is mitigated, no special treatment is provided. In other words, the confinement is merely shortened, although possibly the psychopathic convict might by rights be more properly confined for an indefinite period. The concept that mental impairment short of legal insanity might reduce the degree of a crime, however, was expressly rejected by the United States Supreme Court in a divided opinion in the so-called Fisher case.[8] Professor Weihofen and the present writer were authors of an extended critique of this decision some years ago, maintaining, and the writer thinks rightly, that the dissenting justices, Murphy, Rutledge and Frankfurter, showed a substantially keener psychiatric insight than their colleagues.[9]

Durham Case

There is some doubt whether the Pike and Jones cases, when enunciated in New Hampshire years ago, produced a very profound impact upon legal thinking. There is no substantial evidence that they did, with the one exception of the Parsons case in Alabama. There is no question, however, of the significance of the Durham case, decided by the United States Court of Appeals for the District of Columbia, in July 1954 and embodying in essence the principles of the New Hampshire rule.[10]

The court, in a well-reasoned and well-documented decision, held that "as exclusive criterion the right-wrong test is inadequate, in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied in all circumstances. We find that the 'irresistible impulse' test is also inadequate in that it gives no recognition to mental illness characterized by brooding and reflection and so relegates acts caused by such illness to the application of the inadequate right-wrong test. We conclude that a broader test should be adopted." The court then enunciated the rule as follows: "It is simply that an accused is not criminally

responsible if his unlawful act was the product of mental disease or mental defect."

There is in the Durham decision somewhat less discussion than in the New Hampshire decisions concerning the relationship of mental disease to criminal intent. Indeed, the only reference to such relationship is found in the concluding paragraph of the opinion: "Our traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein, moral blame shall not attach and hence there will not be criminal responsibility." It may be mentioned in this connection that one of the authorities cited was the report of the British Commission on Capital Punishment (1953),[11] which, with only three members dissenting, recommended amendment of the law to abrogate the McNaghten Rules and leave the jury to determine whether at the time of the act the accused was suffering from disease of the mind or mental deficiency to such a degree that he ought not to be held responsible.

Many articles have been written on the Durham case, almost unanimously supporting it. These have included eloquent articles by Judge Sobeloff, former solicitor general of the United States,[12] and by Mr. Justice Douglas of the Supreme Court,[12] besides many signed and unsigned articles in legal journals. The significant point is that practically every writer has hailed the Durham decision as a decided step in advance.* From the psychiatric point of view, it seems quite obvious that the Durham formulation permits a far freer rein to the psychiatrist in giving the facts to the jury, instead of limiting him to a universe of discourse with which he is not familiar. It is no longer necessary for him to discuss right and wrong, irresistible impulse, premeditation, malice, and so on. He may speak as a psychiatrist to the jury; and the jury, in turn, it would seem, is as competent to pass upon this question in the light of the advice obtained as it is to pass upon questions of negligence or the severity of an injury, or the probable duration of a disability. To all who are interested in the Durham case, the writer commends the Isaac Ray Lectures by Professor Henry Weihofen, *The Urge to Punish.*[13]

*There are, of course, dissents. One learned judge (Ref. 12, Howard v. U.S.) expressed himself as unwilling to accept the teachings of such writers as Weihofen, Glueck and Overholser and to reject completely the philosophies of such eminent jurists as Blackstone and Greenleaf.

Model Code

Another recent development, also dealt with by Professor Weihofen, is the attempt of the American Law Institute to draft a new model penal code.[14] The proposed formulation, which is essentially a re-statement of the McNaghten and the irresistible impulse tests, reads as follows: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law." The advantage of the Durham formulation over that of the Model Code is clear. The former is dynamic and adaptable to new developments in psychiatry, whereas the model code proposal is merely a re-statement of two well-established but psychiatrically defective attempts to diagnose mental illness by a single symptom.

On the whole, we have come a long way since a Lord Chancellor of England could state in 1862: "The introduction of medical opinions and medical theories into this subject has proceeded upon the vicious principle of considering insanity as a disease." Dr. S. E. Chaille,[15] writing in 1876, compared this previous utterance with Blackstone's statement (Commentaries, Book IV, Ch. IV, p. 61) that "to deny the . . . actual existence of witchcraft and sorcery is... flatly to contradict the revealed word of God." Chaille added, "These opinions illustrate what profound furrows the ancestral bigotry and superstition of centuries can plough into the best-endowed brains of the descendants of uneducated barbarians."

It may be remarked, too, that such progress as has been made in modifying the concepts of "insanity" has been due to the enlightenment of judges, as expressed in their decisions, rather than to legislative enactments, which tend to "embalm" outworn theories and to make change much more difficult than is the case with judicial interpretation.

Fitness For Trial

This paper has perhaps dwelt overlong on the question of criminal responsibility and its relation to mental illness. The fact is, however, that there is no topic in the relationships of the criminal law and psychiatry which has been more discussed and which has attracted more attention. There are many other aspects of the

problem, possibly less sensational, but nevertheless significant; one of these is the question of mental fitness for trial. Lord Hale, writing in the seventeenth century, said, "If a man in his sound memory commits a capital offense and before his arraignment he becomes absolutely mad he ought not by law to be arraigned during such his phrenzy but be remitted to prison until that incapacity be removed. The reason is because he cannot advisedly plead to the indictment."

The same principle is enunciated over a century later in the Proceeding of John Frith,[16] in this quaint language: "The trial must be postponed to that season, when by collecting together his intellects and having them entire he shall be able so to model his defense as to ward off the punishment of the law."

The criteria for determining the mental fitness of a defendant for trial are substantially different from those used in determining his lack of criminal responsibility. Indeed, the confusion between these two resulted in a reversal in one of the very early New York cases, that of Freeman vs. the People (recently popularized by Earl Conrad in his book, *Mr. Seward for the Defense.*) The question had arisen as to the mental fitness of the defendant, but the court instructed the jury to decide whether he knew right from wrong. The appellate court held that this charge was erroneous as to fitness to stand trial, and reversed the conviction.

A distinction, this time between certifiability and triability, was pointed out in the second reversal of the Durham[18] case. This was to the effect that a defendant who is competent to stand trial may nevertheless be suffering from a mental illness, presenting dangers against which protection is necessary. "Competency to stand trial," said the court, "is entirely different from such soundness of mind as would warrant discharge from the hospital."

Who Raises Issue?

The question naturally arises as to who is to raise the issue of mental fitness for trial. Indeed, what assurance is there that a person who is basically incompetent mentally many not, nevertheless, be put on trial regardless of his mental incapacity? Ordinarily, the determination of this fitness is made by the judge, who may raise the question of his own motion, but more often the question is raised by counsel for the defendant. Then, once the

question is raised, how much evidence must be presented to the judge to compel him to make a determination? Must there be a *prima facie* case, or is a mere suggestion made in good faith sufficient?

The courts have not been unanimous on this point. The Court of Appeals for the District of Columbia decided, in the Wear case,[19] that the court has power only to review the motion and to deny it when the ground alleged is frivolous, or when the motion is not made in good faith, thus precluding any weighing of evidence by the court to determine whether there is reasonable cause to believe that the defendant is mentally ill. Because such a motion was denied, the conviction of Wear was reversed. This may seem a somewhat exterme decision; and yet, provided psychiatric facilities are readily available to the court, there would seem to be no reason why the benefit of the doubt should not be given to the defendant to the extent at least of causing an examination to be made.

Parenthetically, it may be remarked that sometimes the discretion of judges is not conspicuous by its presence. The papers recently reported that a judge in New York City ordered a prisoner to trial, although the report from Bellevue was to the effect that the defendant was decidedly psychotic and unfit for trial. Fortunately the issue was resolved in another court by the commitment of the defendant to a mental hospital. Such cases, of course, are the exception, but one has the uneasy feeling that there may be cause in which a defendant is put on trial who is mentally incompetent.

Briggs Law

It was to remedy situations of this sort, as well as to prevent —as far as possible—the battles of experts, that the Briggs Law of Massachusetts was enacted in 1921. The provisions of this law, which the writer has considered elsewhere in considerable detail,[20] are as follows: Persons indicted for a capital offense and others bound over or indicted who have previously been convicted of a felony or indicted more than once are referred automatically to the State Department of Mental Health for a mental examination.

This examination, then, is made not because anyone raises the issue, but because the defendant falls into one of certain legal categories. It is made by experts who are appointed by psychi-

atrists rather than by the district attorney or the court. Thus, the examination is not only automatic but competent and impartial. In practice a defendant who is reported to be in need of care in a mental hospital is certified; later on, if he recovers he is returned to the original custody and may then be tried if the district attorney sees fit. It is equally obvious that if the report is to the effect that no mental disorder or disease is found, it is highly unlikely that the jury will accept a different opinion from a privately-employed psychiatrist called in behalf of the defense. Thus justice has been done to the mentally ill defendant, specious pleas of insanity have been virtually eliminated, and the public has been spared the spectacle of seeing apparently equally competent men arrayed against each other on the witness stand.

The public mental hospitals in general have an important part to play in the criminal process, since they may be called upon to examine and report on defendants who are sent to them for observation and treatment. Some courts have established clinics which may after examination recommend trial or observation in a hospital. Instances have, to be sure, occurred in which reports from public institutions and public clinics have been disregarded, but these, after all, are decidedly in the minority.

Credibility

Still another possible contribution of psychiatry to the criminal process has to do with the credibility of witnesses. Much interest was focused on this problem during the trial of Alger Hiss; and psychiatric testimony of a sort was introduced as to the credibility of one of the prosecuting witnesses. The concept that mental illness or deviation may be an important factor in the testimony of the witness is not a particularly new one, in spite of the fact that at the time of the Hiss trial much was made of the supposed novelty of offering such evidence. As far back as 1854 in a New York case,[21] this very question came up.

The principal witness then was a woman of allegedly "imbecile mind and memory." The judge excluded the testimony of a witness on the subject of the imbecility on the ground that the objection was offered too late, but this was held to be error. The Appellate Court ruled that such testimony is admissable to affect the credibility of testimony, even though not offered as an objection to the competency before the witness is sworn.

Another early case occurred in England in 1851,[22] in which a patient in a mental hospital witnessed the killing of another patient. In spite of the fact that he was actively hallucinated, and thought he was controlled by spirits, he, nevertheless, apparently was able to give a clear account of the event; and, upon examination by the judge, his testimony was admitted, the court adding that the weight of the testimony is for the jury. One of the judges, Lord Coleridge, remarked rather wryly that a strict rule against permitting persons with delusions to testify "would have excluded Socrates."

A recent article on this topic in the *Vanderbilt Law Review*, after citing many cases in which such testimony was permitted, states that the effect of mental illness upon competency is a preliminary question for the court and that most courts admit such evidence, both medical and lay. The article utters the caution that the opinion should be based on complete knowledge, and adds that such a practice should be widespread, although subject to continuous and rigid scrutiny by counsel and court.

In cases involving sex offenses in particular, it would seem that a procedure of this sort is highly commendable. Indeed no less authorities than Wigmore and the American Bar Association's Committee on Evidence recommended that in all cases charging sex offenses, the complaining witness should be examined before trial by competent psychiatrists as to her probable credibility. Orenstein,[24] as a result of his experiences in the New York Court of General Sessions Clinic, has pointed out several cases in which, unquestionably, persons had been wrongfully convicted of sex offenses on the unsupported testimony of girls who were demonstrably mentally deranged. It is not at all improbable that in the future more use will be made of psychiatric evidence as to the credibility of witnesses.

Expert Testimony

A full consideration of how psychiatric information is to be brought to the attention of the court and jury would lead us into a discussion of questions of expert testimony in general which is far beyond the scope of these remarks. They were considered at some length in an article in the *Journal of Criminal Law and Criminology* for September 1951.[25]

The problems of psychiatric evidence have plagued lawyers and

psychiatrists for many years and are far from being settled even yet. To show that there is nothing new about the problem, it may be mentioned that in 1880 before the Royal Medico-Psychological Association, Dr. D. Hack Tuke expressed the aims of expert psychiatric testimony as being to adopt the most scientific means of ascertaining the mental condition of the accused, to protect him from punishment if he is irresponsible, to protect society from false pleas of insanity, and to avoid discharging the mentally ill until it is safe for them to be at large.

In the course of the discussion Dr. Henry Maudsley remarked that he was afraid that "our legal dignitaries had not the least desire to be helped out of their dilemma," adding that, from his earliest recollection, "they had been hammering away at this subject." One should mention the long labors of Professor Keedy of the University of Pennsylvania, who in 1915[26] made recommendations concerning an improvement of the situation. The Briggs Law of Massachusetts has already been briefly described as at least a partial solution.

In 1938, the Commissioners on Uniform State Laws proposed a Uniform Expert Testimony Act which, however, has not as yet been enacted in *any* state in the union! Briefly the principles were: authority to the court to appoint expert witnesses; notice to the parties, if the court appoints; notice to the court when the parties appoint; agreement on expert witnesses; inspection and examination of subject matter by these experts; a report by the experts and filing thereof; conference and joint report by the expert witnesses; calling of the expert witnesses by the court or parties; and permission to the experts to state their inferences without first specifying hypothetically the data on which the inferences are based. Finally the compensation of the experts would be fixed by the court. The failure of the states to enact this legislation is an interesting commentary on the delay of procedural reforms.

Another activity of interest, now unfortunately in abeyance, was the active collaboration of the American Psychiatric Association with the Criminal Law Section of the American Bar Association, originated through the activity of Dr. Karl A. Menninger in 1927, and continued for about 10 years. The Criminal Law Section urged in 1929 a far-reaching program of integration of psychiatric services with courts and correctional institutions. Their recommendations were a stimulus, at least.[27]

Individual Treatment

As the recognition has grown that offenders are not all cast in the same mold, and along with the development of psychiatric knowledge, there has been a trend in the law toward greater specialization, particularly in dispositions. Probations and parole were among the early modifications, tending toward an individualization of treatment. The juvenile court is of course another excellent example, as is the indeterminate sentence. Special provisions have been enacted in some states for the treatment of the so-called defective delinquent and for treatment of drug addicts and alcoholics, as well as special institutions for the criminal insane.

More recently we have seen a growth in the concept of a youth correction authority—and, indeed, in California, of an adult correction authority as well. More than 20 states have enacted what are known as "sexual psychopath" laws. This latter group of laws in particular is a recognition, sometimes rather fumbling, but nevertheless indicating that the law recognizes that there are persons who, so to speak, are neither black nor white but gray. The "sexual psychopath" is recognized as not legally "insane," yet at the same time as sufficiently deviated from normal, not to be amenable to the routine penal or correctional procedures. The sexual psychopath laws are generally open to serious criticism in detail, and yet they do open the way toward an even greater specialization, and toward recognition of the fact that, contrary to earlier beliefs, the human race does not fall into two categories, those who are completely "sane" and those who are completely "insane."*

Disposition Tribunal

It seems not unlikely that as understanding of human conduct develops still further we may expect to see a closer approximation of the two concepts of punishment and treatment. Indeed, we should perhaps look ultimately for what Francis Wharton[29] recommended a century ago—a disposition tribunal. This has been seriously proposed more recently by Sheldon Glueck and by others. Wharton recommended that the trial should "confine its inquiry to the mere factum of the commission of the offenses, reserving the question of treatment to be determined by a special commission of experts."

*For an excellent discussion of this problem, see Guttmacher, Ref. 28.

The state of Washington tried something of the sort in 1908, but that provision of Washington law was overturned in the Strasburg case. Perhaps even today a proposition of the sort would require a constitutional amendment. If, however, the question of the mental state of the offender could be made an administrative matter, to be determined after the jury has found that the offense was committed, the battles of experts would virtually cease and a much sounder correctional policy would be in effect. Even though this development is not yet exactly in sight, there is no doubt that progress has been made, and that more progress will come about.

Certainly, as the public becomes better educated as to psychological mechanisms, and as psychiatry progresses, we may expect still further advances in a more humane, a more intelligent, and a more effective disposition and treatment of the offender against the law.

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REFERENCES

1. Glueck, S.: Mental Disorder and the Criminal Law. Chapters 5 and 6. Little, Brown. Boston. 1925.
   Diamond, B.: With malice aforethought. Arch. Crim. Psychodynam., 2:1, 1957.
2. Mudway v. Croft, 163 Eng. Rep. 863 (1843).
3. St. v. Thompson, Wright's Ohio Rep. 617 (1834); and Clark v. St., 12 Ohio Rep. 495 (1843).
4. St. v. Pike, 49 N.H. 399 (1870).
   St. v. Jones, 50 N.H. 369 (1871).
5. Parsons v. St., 81 Ala. 577 (1886).
6. Peo. v. Moran, 249 N.Y. 179. Comment by H. Weihofen, 24 Ill. L.R. 505.
7. Polsky, S.: Chapter 14, Psychiatry and the Law. Paul Hoch and Joseph Zubin, editors. Grune & Stratton. New York. 1955.
8. Fisher v. U.S. 328 U.S. 463 (1946).
9. 566 Yale L. J. 959 (1947).
   Keedy, E. R.: 99 U. of Penna. L.R. 267 (1950).
10. Durham v. U.S. 214 F 2nd. 862.
11. Command Papers 8932, p. 276. H. M. Stationery Office. London.
12. Sobeloff, S.: PSYCHIAT. QUART., 29:357, July 1955.
    Douglas, W. O.: Law and Psychiatry. Pub. William Alanson White Inst. of Psychiatry, Psychoanalysis and Psychology, N.Y. 1956.
    Symposium, 22 U. of Chi. L.R., Winter 1955.
    Bailey, M.: 29 Temple Law Quarterly 338. Spring 1956.
    Howard v. U.S., 232 F 2nd 274 (1955).
13. Farrar, Straus & Cudahy. New York. 1956.
14. Tentative Draft 4. Phila.: Am. Law Inst. Art. 4, Sec. 4.01.

15. Chaillé, S. E.: Origin and Progress of Medical Jurisprudence 1776-1876. Reprinted in: 40 J. Crim. Law 397-444 (1949).
16. 22 Howells St. Trials 307 (1790).
17. 4, Denio 9 (1847).
18. 237 F 2nd. 760 (1956).
19. 218 F 2nd. 24 (1954).
20. Overholser, W.: 35 J. Crim. Law 859 (1935).
21. Rivera v. Ghio, 3 E. D. Smith Rep. 264.
22. R. v. Hill, 2 Denison. Cr. Cas. Res. 254.
23. Watts, T. E.: Psychiatric challenge of witnesses. 9 Vanderbilt L.R. 860 (1956). Psychological evaluation of the mentally abnormal witness. 59 Yale L. J. 1324 (1950).
Wigmore on Evidence. Third edition. Sec. 924. Little, Brown. Boston. 1940.
24. Orenstein, L.: Am. J. Psychiat., 107:684 (1951).
25. Overholser, W.: Psychiatric expert testimony in criminal cases since M'Naghten —a review. 42 J. Crim. Law & Criminology, 283 (1951).
26. 5 J. Crim. Law. 643 (1915).
27. Overholser, W.: Ten years of cooperative effort. 29 J. Crim. Law 23 (1938).
28. Guttmacher, M.: Sex Offenses. Norton. New York. 1951.
29. Wharton, F.: A Monograph on Mental Unsoundness. Kay & Bro. Philadelphia. 1855.

SOME OBSERVATIONS ON ART AND PSYCHOTHERAPY WITH SPECIAL REFERENCE TO SCHIZOPHRENIA*

BY G. M. DAVIDSON, M.D., AND BEATRICE VORHAUS WISE

Orientation

From the autumn of 1954 to the spring of 1955, an art project for patients was conducted at the Manhattan State Hospital by one of the writers (B. V. W.). It became apparent that the project had both enough therapeutic and research value to call for an investigation. This paper is a report of the study that followed. Patients were referred to the art classes by the staff physicians, other hospital personnel and participating patients themselves.

The classes had about 10 patients each; they were held both indoors and outdoors. The outdoor classes were called "landscape parties," and their object was to observe the patients' reactions to "nature" in contrast to indoor work which was given to arouse patients' "spontaneity." Of the large group of patients attending, 30 were studied in some detail. Those who showed good adaptability received individual psychotherapy. Of the latter group, four patients of different psychiatric classifications are presented here. The patients studied were of both sexes; they were representatives of the cultural and subcultural divisions of the population of metropolitan New York; their ages ranged from 17 to 48 with a preponderance of the 20 to 30 age group; their psychiatric classifications included certain types of personality disorders, psychoneuroses, and—principally—schizophrenia.

During the year of study considerable art material was accumulated which particularly reflected psychopathology, and at the same time, offered diagnostic and prognostic clues. To evaluate the material properly, an approach had to be formulated and devised, a difficult matter because of lack of real knowledge on the subject, in spite of the availability of *words*—so often used to fill gaps in knowledge. The danger here was that suitable stopgap words might become so familiar in time as to stop further inquiry by seeming to explain rather than cover up the lack of explanation. At this point they might well stop further inquiry into the aspects of the subject to which they relate.

Take, for instance, the words "art" and "psychotherapy," the

*From Manhattan State Hospital, Ward's Island, N. Y.

"cornerstone" concepts of this presentation. At first glance, one seems to know all there is to know about the subjects the words cover, and yet any attempt to define either may—in our present state of knowledge—be easily challenged. On the other hand, since what is meant must be established, incomplete definitions may be excused here. Accordingly, one may say that *psychotherapy* is a *technique* of mental healing which makes use of such conscious and—particularly—unconscious mental contents and mechanisms as may be basically ascertained by the psychoanalytic method. That method is facilitated by the principle of *transference* and is displayed on the level of *language,* which in turn is an expression and symbolization of ideas and feelings. Regarding *art,* one may say that *fine art* incorporates, in a *design,* expression and symbolization without the need of external stimulation. Thus we have a *language* of *art.* As Sir Herbert Read puts it: "Art is not only creation but also communication." Again, Naum Gabo observes: "Art as a mental action is unambiguous—it does not deceive—it cannot deceive, since it is not interested in truths... we should not search in works of art for truth—it is verity itself." It follows that *language,* the motor end of thought (there is no thought without affectivity), and an "instrument" in the process of *transference,* will be enhanced by art, thus the therapeutic process.

Having arrived at this formulation of operational concepts, the next step was to develop a method to decode the message contained in the design of a painting by a patient. While the design represents a *Gestalt,* the configuration incorporates, among other things, *space, form* and *color.* It is this triad *in toto* or in its component parts, in its abstract or concrete expression, that serves as a basis for interpretation. In a clinical sense, the triad (or parts of it) is a constituent of the total personality. To find the relationship of the design (the triad) as a part to the whole, the totality, the patient is requested to give his associations to the triad. The associations, together with the patient's history, ultimately bring about the interpretation.

To call further on the psychiatric principle of the total personality the design should be interpreted not only in psychological terms, but also in psychophysiological ones. Surprisingly enough, more students of art than of the mind appear to have attempted this. Bernard Berenson, for example, differentiates *tactile, visceral*

and *respiratory* values of a design. These will be discussed with the already mentioned triad of space, form and color, with the understanding that parts of the triad, as well as the *values* are interwoven and are separated here for the sake of presentation.

To begin with, one may quote Bergson: "A body is essentially what it is to touch. It has distinct shapes and dimensions which are independent of us. It occupies a given space and cannot change it. ... The visual image that we have of it we judge to be a mere appearance whose different aspects must always be changed by reference to the tactile image. The image is the reality to which the other draws our attention."

Berenson points out that *form* must never be confused with *shape,* which is a geometrical construct, looking the same to everybody. *Form* is a quality beyond shared cognizance, implying individuality. Moreover, it appears to the writers that in a psychological sense *form* cannot be isolated from *content.* Again, it cannot be isolated from *movement.* In summary, *form* when considered in the way described, will promote the sense of touch of the observer. In other words, *form* will, or will not have *tactile value.* According to Berenson *form* which has *tactile value* is *life-enhancing,* and it is for this reason that the "vulgarity of certain forms, such as the paintings of Degas of far from appetizing ballet-girls are appealing to us; they vitalize us with transmission of energy." On the whole, *tactile value* refers to our "corporeal" contact with the *outer world.*

As for *color,* it may be said that color may be used for its own sake, as well as for the sake of form. Color accelerates perception of form, movement and tactile value. Again, color may be reduced to a most direct sensuous appeal. In the latter use, it may outweigh any ideation which may be conveyed by the design. According to Ruskin (quoted by Read): "All men ... enjoy color; it is meant for the perpetual comfort and delight of the human heart; being associated with *life* in the human body, with *light* in the sky ... death, night and pollution of any kind is colorless." In summary, color is identified with emotional expression and so corresponds to Berenson's *visceral value,* referring to feelings of comfort and discomfort *inside* of *us.* (One may think of such terms as "warm" or "cool" colors.)

The final member of the triad, *space,* is judged by the execution of the design as reflected by "organization of space" by the

painter. It implies freedom or lack of it, giving at times the "illusion of soaring into harmonious relationship with the sky and horizon" (Berenson). The opposite implies anxiety. On the whole, space is related to Berenson's *respiratory value.*

The next step is to combine the foregoing with the expression of *psychic* needs of the individual. One must differentiate here the *psychic* need of *communication* (companionship in Suttie's sense), and the *psychic* needs of *security, recognition, emotional response,* and *new experiences* (in Linton's sense). The concept of *psychic* needs is broader than the concept of *libido.* It covers not only libidinous, but social, economic, and other values.

In combining *psychic* needs with "psychophysiological" expressions of *design,* it is postulated that *tactile* value, as expressed in *form,* content and *movement,* is a reflection of the psychic need of communication, and indicates the state of interpersonal relationship of the patient. *Visceral* value, as expressed in the use of *color,* reflects the psychic need of recognition and emotional response and covers the emotional sensitivity of the patient to various challenges of life. *Respiratory* value, as expressed in *organization of space,* reflects the psychic need of new experiences and the degree of conflict over the need for freedom, achievement, activity, and so on. The degree of expression of the tactile, visceral and respiratory values—as may be judged from the presence or absence of movement, the amount of pigment used, or other factors —is indicative of the acuteness of the respective psychic need, struggle for progress, and so on. *Organization of Space,* together with the nature of *form,* is a reflection of the conceptual thought of the individual.

One may now turn to the clinical material and see how the foregoing is expressed in individual cases.

Clinical Material

Case 1. *Sociopathic Personality Disturbances*

The record of the Case 1 patient reveals that he was certified to a state hospital after a mental examination on a city observation ward following a charge of burglary.

He was 22, single, no occupation, born in the United States of mixed white and Negro race. He was the only child of a father who was 47 at the time of the hospital admission, and was a meek and passive individual, and of a mother, then 40, who was active,

obsessional and a domineering person, pressing the patient since early life for greater achievement. The patient was an instrument delivery (no known damage), was breast fed, talked and walked early. His infancy was marked by strong attachment to his mother. From the ages of five to 12, he had "asthmatic" attacks at night. When a physician would come, there would be no evidence of anything specific except forced breathing. He had the usual childhood diseases without apparent sequelae. His early school record was good; and he skipped grades in elementary school. In his third year of high school he lost interest in his studies and dropped out, ran away from home but returned. He was allowed to finish high school at night, which he accomplished at 17. He had difficulty in obtaining work because of his age and had to lie about it. After he found a job, he did not apply himself well and at 18 joined the army, becoming a paratrooper. He was discharged a year later for medical reasons (there was a return of his "asthmatic" attacks).

After his army discharge, he could not adjust at all; on the day after the discharge, he was arrested for disorderly conduct; and he had several subsequent arrests for such antisocial activities as disorderly conduct, reckless driving, petty larceny and finally, burglary. About six months before his hospitalization and his last arrest for burglary, he began to use *heroin*. (The need of money for drugs prompted his taking part in the burglary.) There was a previous admission to a Veterans Administration hospital "in order to get out of a court case." While there he was noted as "a very bright young man who appeared sexually and socially retarded by a prolonged adolescent rebellion characterized by dislike of authority, masturbation guilt, dependency-independency conflict, and a tendency to overemphasize his sexual prowess." He was described further as being "always on the go," restless and unstable particularly with reference to the opposite sex, poorly adapted to work—and with increased instability and irritability after his army service.

In the state hospital, the patient was found to be in good general physical condition. He was six feet, one inch tall, and weighed 175 pounds. The examination and laboratory tests inclusive of an EEG showed no pathology. The mental examination showed he was in good contact but reserved, somewhat depressive and self-absorbed. There were no abnormal ideas or specific emotional

abnormalities. He made an excellent hospital adjustment. Psychological tests showed him to be an "insecure, childishly dependent person... his libidinous impulses being guilt-laden with fear of homosexuality."

His application to psychotherapy and art have brought out the following pertinent information. He spoke of his mother as adorable, lovable, etc. She was for him the "ideal woman and wife." He spoke of his father only casually but in conciliatory terms. His "asthmatic" attacks were symbolic of craving for his mother's care and of fear of abandonment. When he began to masturbate, the attacks subsided. (Masturbation may be regarded here as a defense and a way of gaining independence.) His change in high school was attributed to delayed maturation—in late development of pubic hair, and in lack of an emission while masturbating. He was afraid of not developing into a man. This was one of the reasons he joined the paratroopers—a heroic effort to prove his masculinity. For the same reasons he was overindulging in sexual relations. (He was considerably taken aback by a girl older than himself who, after his first sexual session, called him a "kid.") He tried homosexuality in a passive way (fellatio). He toyed with the idea of homosexuality for money, but was afraid and ashamed. He was once engaged to be married, but broke the engagement, fearing that he could not cope with the responsibility.

In his art work, striking traits with reference to *color* and *form* may be noted. Besides using *blue* to indicate feminine identification, he used it to show composure. *Red* meant masculinity and excitement; *light green,* life. *Yellow* was used particularly for hair that he liked; and *brown* for shading. He employed *form* in both a realistic and abstract manner.

A few pieces of work which were significant of his mental state in his early, middle and late residence in the hospital are described here. One drawing, painted in blue, shows a boy who has a heavy weight attached to him. In another, a figure in blue is running away from a syringe in red, as from the effect of an injection graphically depicted as influencing his head. There is a composite picture of aggression, showing dentures in red with a symmetrically placed cylinder in blue (a cigarette) going up in smoke; a foot stepping in a forbidden place, and a red circle and an oval (which seem to be an attempt to isolate the difficulty). There is also

another circle which seems to be a flashlight, like an eye, keeping watch over his activity.

Another drawing shows a boy kicking a girl away (Figure 1). Both the boy and girl are drawn half-blue and half-red, signifying both masculine and feminine personality components. The patient's comments are that he can find no proper relationship either with himself, or with the girl (Figure 1). Another drawing shows a hand, "the doer" which controls the mind, as well as emotional experiences.

There is also a picture of a child holding a doll. It signifies, to the patient, the childhood feeling of being satisfied in possessing a most appreciable thing. In applying the lesson to his present state of mind, he believes that he has learned to appreciate small things.

There is a small figure of a Negro boy (with the face resembling his own) who tries to reach "higher things." In addition, the "Negro" depicts the "dark side" of the patient's personality that he tries to fight off.

Finally, there are two oil paintings. One shows a young man (resembling the patient) with emphasis on the "mouth" (fellatio practice); and the other, demonstrates "displacement upward" of the genital area (Figure 2). The mouth and the triangle of pubic hair distribution around the head are painted red. A "breast" is suspended from the head (the patient had no interest in the body of a woman below the neck).

These drawings are concerned chiefly with the patient's problems. As far as *tactile* value goes, the "personal" drawings show a fair degree of its presence. This is not so in his "landscape" paintings, which thus reflect meagerness of interpersonal relationships. *Visceral* value was strongly represented in the acute stage of illness, showing considerable use of pigment. This testifies to the mobilization of emotions. Later *visceral* values were "smoothed" over, which was concomitant with a return to his usual behavior. *Respiratory* value was marked by drive for achievement.

Diagnostically, the drawings were in keeping with the man's classification. Prognostically, the forecast was for improvement under controlled conditions.

Case 2. Psychophysiologic Nervous System Reaction

Patient No. 2 was in the hospital only a short time. Therefore,

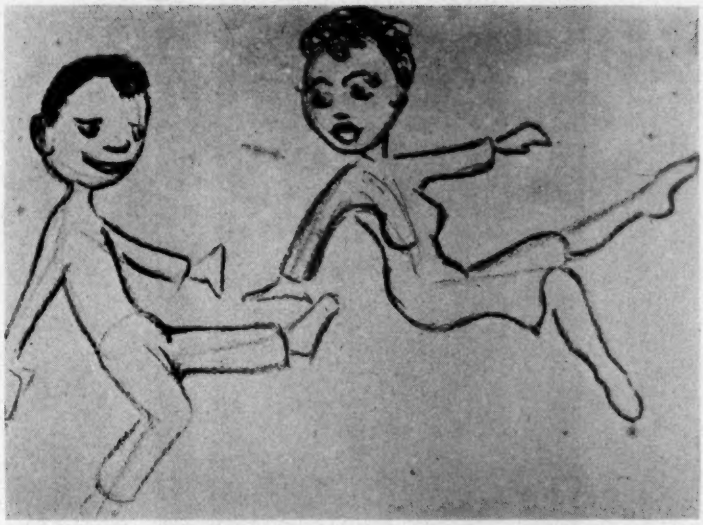


Figure 1. The patient (Case 1) drew both girl and boy half-blue and half-red, the blue representing, for this patient, feminine components, the red, masculine.

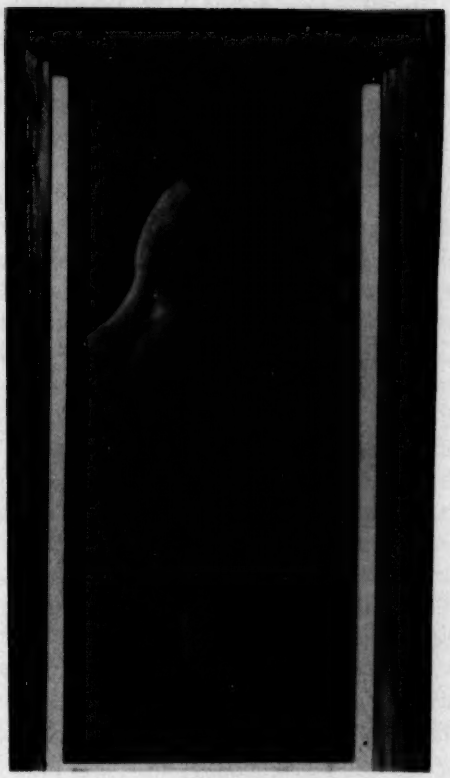


Figure 2. An oil painting by the patient in Case 1. The triangle is displacement upward of the genital triangle, and is in deep red (which meant both masculinity and excitement to the patient), as are the lips and the nipple of the breast suspended from the head. The face is of a white girl, and the hair is yellow—a color the patient used for hair that he liked.

the work done with him was limited. He is presented because of his considerable artistic ability, which came to the fore here, and because his drawings mirrored his conflict so well and helped in making the brief psychotherapy successful.

He was a single man of 24, a Negro and a World War II navy veteran. He was an automobile mechanic. He presented himself to a city hospital for a "check-up," because he felt tired, sleepless, irritable and, above all, was "giving off heat." He was certified to a state hospital. According to his record, he was born in Puerto Rico, the second of two children. His mother had to work, and he was taken care of by a "hired woman" until he was four, when his father took him to St. Thomas, in the Virgin Islands, to stay with his grandmother. Afterward he was seen by his father only occasionally until he was eight, but when he was six, his mother came for him. He did not recognize her; she was a total stranger to him, although he became fond of her later. When he was eight his mother re-married. He resented his stepfather and was rather hostile toward him, but came to terms with the situation after his discharge from the navy. When he was 14, his family had moved to the United States. His school record was good until his adolescence, when he was emotionally restless and "could not apply himself" to study. He completed high school only after leaving the armed services. He had joined the navy at 18, and was honorably discharged when he was about 23. Then he joined his family and worked as a mechanic until his hospitalization.

He became active sexually at the time of puberty and has been overactive in his relations with women since. According to the patient he could find "something attractive in any woman." During the year before his illness, he had "kept company" with a certain girl. While she was not "the" girl and he also associated with others, he felt greater responsibility toward her than toward others. He had been homosexually approached, particularly during his navy service, but said that the experience did not go further than an attempt. However, he said that he found some men attractive and was pleasantly aroused by them. At the same time, he was afraid of this reaction; and, when it occurred he withdrew from the situation.

He described himself as friendly socially, but uneasy with many people of both sexes (the reasons will be seen later). His intelligence is good.

Toxic influences were denied; and the medical history showed no significant diseases. In the hospital he was found to be in good physical condition. Laboratory tests inclusive of an EEG showed no disorder, and no neurological abnormalities were found. The mental examinition showed him to be pleasant in attitude and effeminate in manner. He was animated and talkative. There was no disorder of the stream of thought and no abnormal emotional reaction. There was no evidence of abnormal trends. He was preoccupied with his feelings of emanation of heat from his body. However, he said in response to questioning: "It does not affect other people . . . it does not prevent me from doing things . . .it has cut down on my social life. . . . I don't like to socialize when I am that way. . . . It increases my body odor." His sensorium was clear.

Psychotherapeutic interviews with the patient produced, in addition to the foregoing, the following data on his problem. It appeared that the "emanation" of heat with accompanying symptoms of flushing, perspiration, and so on showed itself around puberty, when he began to show sexual interest. It became noticeable during dancing, for instance. A stronger feeling of emanation of heat was noticed at 15 when his stepfather suffered severe burns in an explosion (the boy was frightened). The most striking appearance of feeling of heat occurred during his service in the navy, apparently in reaction to homosexual approaches. The present extreme "heat wave" occurred in reaction to his having been discovered by his girlfriend in sexual intercourse with the girl's cousin. The girlfriend became violently excited, cut up the patient's jacket and called the police. He fled in fear. In addition, he felt humiliated at having been "found out." Besides this incident a fellow-worker had caught his hand in a machine four days before the patient's hospitalization, having three fingers cut off (castration fear).

While the feeling of heat was more likely to occur in relation to sexual situations, it came out that the patient also had similar feelings in reaction to other life situations, such as meeting certain people—or in situations which would arouse anger or defiance (racial discrimination, etc.).

Through the psychotherapeutic sessions, the patient understood in a broad sense that his feeling of emanating heat was caused by his emotional reactions to various stresses, sexual or social in

character. He quickly grasped the meaning of his early experiences and the effect they had had on the present problem. (For instance, there was the feeling of neglect by the mother—not recognizing her when she claimed him; the neglect and abandonment by the father; and the need to adjust to a stepfather.) Sexually, this made him as if in continuous search for "the" woman (the mother). On the other hand, his search for the father contributed to his homosexual interest. Socially, the ambivalent attitude toward his parental figures caused uncertainty in meeting people, as the result of uncertainty about himself.

With the foregoing in mind, there ought to be a few words regarding the nature and possible origin of "heat." The following may be differentiated: (1) heat as a psychophysiological autonomic disorder; (2) heat as a symbol; (3) heat as a manifestation of autonomic diencephalic epilepsy; and (4) as a delusion. The last can be easily ruled out, because the patient could be reasoned with very well on the subject; furthermore, he did not handle the situation either in a delusional, or an obsessional-delusional way; there was no projection, or similar phenomenon. Diencephalic epilepsy could be also discounted because of the complete lack of such a clinical syndrome. As symbolism, one could interpret the "heat" as symbolic for "burning up" with an unconscious libidinous urge. This would be correct; but, from a broader viewpoint, what appears to be most outstanding is an exaggerated state of normal physiological autonomic function, psychologically-conditioned and elaborated.

It is of interest to note that the "heat" would be occasionally appreciated as smell. The latter is symbolic of "guilt." For further details of the significance of "smell," see Davidson on the subject in the bibliography.

This patient's drawings showed progress from morbid scenes in black and white to the use of color and more adequate life situations. One drawing is of a coffin with the patient kneeling before a priest. His comment was that the coffin stood for his fear of death and retribution for his doings. The drawing showed him trying to return to religion.

Another drawing (Figure 3) depicts a scene from life in the navy. It shows the patient emanating heat, radiating toward a man to whom he gave his identification card and a pass to go on a date (defense against homosexuality). Still another drawing

(not shown) portrays his fear of people. Finally, one represents an "enjoyable" scene of firing an anti-aircraft gun. Toward this end, the patient related a memory of his fear of the sea in his childhood while being taken out on a boat. In comparing the childhood event with the pictured boat, equipped with a gun, the libidinous and social implications are obvious.

The drawings demonstrated very good *tactile* value (comparable to good interpersonal relationships). *Visceral* value was marked by a "warm" tone; the use of pigment was eccentric at times (comparable to lively emotional reactions to situations). *Respiratory* value was good. The patient was able to "organize space" well. Diagnostically, the drawings helped to establish that the patient's case was not one of schizophrenia as originally thought. The drawings also indicated a good prognosis.

Case 3. Psychoneurosis, Anxiety Reaction

The patient in Case 3 presented himself to the hospital requesting admission because he used "goof balls, paraldehyde, whiskey, and drugs." Moreover, he wanted "relief from hostility."

His record revealed that he was a 31-year-old artist, separated from his wife. He was born in the United States of Polish parents, the youngest of four children, the other three being girls. His father left the family when the patient was nine months old. His mother was "crazy clean" in a "sterile way." The patient had "hated her" since early in life. He "did not recognize her" as a mother, and later in life was ashamed of her. From infancy, he formed a strong attachment to his oldest sister who was 18 years his senior. The attachment had an incestuous character. When he was five years old, this sister took him on her honeymoon; and, when she later had a son of her own, she preferred her brother. The patient had ambivalent feelings toward the middle sister. The youngest sister had run away from home with a Negro.

The patient's earliest memories reveal that at about the age of three, while sharing a bed with his sister, he woke up gasping for breath, a feeling that he identified with an anxiety state. (In a "longitudinal way," this may have been the onset of his difficulties.) At a somewhat later date, he recalled playing "king" and being lifted up in the arms of two boys. Still later, he remembered that, while being ill with *diphtheria*, he felt as if he were dying and suffered great apprehension. He remembered that when he was six he was almost overrun by a truck which was

Figure 3. The patient (Case 2) is the seated figure. He is emanating heat—the markings above him, red in the original—toward a man with whom he served in the navy.

approaching him with glaring headlights. He remembered that he fainted. At about eight he was hit by a schoolmate in the stomach during a fight that he was about to win. He lost and felt humilitated. Since that time, he said, he had developed anxiety states at almost any provocation.

His school record was good. He was graduated from high school and, after returning from the army (he served from 18 to 22), studied art under the G.I. Bill.

In addition to what has already been said about his psychosexual development, the patient believed he became conscious of sex when he was about eight and used to play "house," pressing himself against little girls, and so on. At about the same time, he remembered, he become conscious of the size of his penis, comparing it with other boys' penes; he felt that his was undersized. He learned to masturbate at about the time of puberty. At 16, he had his first heterosexual contact with a woman of 30, and had been sexually active since. There were also homosexual practices, but the patient was reluctant to talk about them. At 23, he married a girl of 17, who had been sexually maladjusted since early life. The marital relationship was "hectic" but "fabulous." Both had extramarital affairs. The patient would be "tormented" by his wife's account of her lovers, particularly about one man who had an "enormous" penis. He "felt" the smallness of his penis, especially after his wife's childbirths. There were three children, who were neglected to the point of court interference. After the third was born his wife left him with another man. During their life together, the wife had attempted suicide three times. The patient's children are now being taken care of by the wife's family. After his wife left him, he felt sexually impotent and "numb."

Alcohol and Drugs

The patient began to drink at the time of his marriage. According to him, he drank both to counteract his difficulties and for a good time, since he enjoyed his actions when he was inebriated. Another reason for drinking was to "belong" to the family of his wife who were drinking people. He also used drugs to counteract the influence of alcohol. There was a history of delirium tremens as a reaction to withdrawal from alcohol, with a short residence in a sanatorium. He was associated with Alcoholics Anonymous, and at one time, was able to abstain for six months.

He was otherwise described as a sociable and friendly person, who lacked discrimination in the use of money. He never developed responsibility enough to work and maintain himself. His wife's family was wealthy and supported him.

His mental difficulties were described as severe *anxiety states*. He was free from these when he applied himself to art, and he was also free during army service, a fact which he believed was due to being away from home. Three months after his discharge from the army, at which time he met the girl he married, he commenced to have anxiety states again.

In the hospital this patient appeared effeminate. He was found to be in good physical condition, five feet six inches in height, 149 pounds in weight, left-handed. Laboratory tests, inclusive of an EEG, showed no abnormalities. His mental state was tense; otherwise, his emotional reactions were appropriate. He was overproductive, but no abnormal ideation was noted. His sensorium was clear, and he adjusted well.

He attended art class, received brief psychotherapy with apparent beneficial results, and was discharged after about 60 days. For the first time in his life, he then found work and was self-maintaining.

In art, he identified himself chiefly as an abstract painter. He liked to create new variations of flowers and was working on a project of "fertility." His favorite colors were *mauve, lavender, blue* and *green*. He disliked *brown*. (The choice of colors is indicative of feminine identification and of rejection of his mother.) In the hospital he drew rather a lot, enjoyed landscape painting which he never did before. A few paintings deserve comment. He drew a painting of a three-headed Christ on the Cross which could be interpreted—on the basis of his associations as a reinforcement of masculinity and spiritual values (Figure 4). (The patient was a member of the Bahai sect.)

Another painting of Christ-in-three depicted one Christ on the cross, a second embracing the Christ on the cross, and a third being touched by one hand of the Christ on the cross.

The patient's comments were referable to narcissism and homosexuality. In addition there was a suggestion of the patient's identification with God, father, and lover (self-in-three, the figures of Christ showing definite resemblance to the patient). Another drawing showed the patient's problem. It portrayed a face divided

Figure 4. The colors favored by this patient (Case 3) indicate feminine identification. The three heads of Christ are blue, with green tints. The beards are tinged with red. The cross is olive green.

in two on the horizon; the one facing a pair of trees representing his sister and her husband (the patient identified them with his parents); the other half facing another tree which gives off three branches (apparently symbolizing his wife with three children).

The evaluation of this patient's work is of particular interest because the patient is an artist. The drawing displays poor *tactile* value. There is confusion and vagueness of form and content. This corresponds with the patient's confusion over self-identification, as well as his vagueness in interpersonal relationships. *Visceral* value was expressed at times in heavy use of pigment in an "inkblot" way. At other times, very little pigment was used, a fact pointing to moodiness, anxiety and emotional insecurity. *Respiratory* value showed marked restriction of freedom. Mental improvement was reflected in the work by way of better expression of values, which, in turn, gave a good representation of his conflict.

Case 4. Schizophrenic Reaction, Catatonic Type

Patient No. 4 was admitted at 20 for a second hospitalization with a history of being an unwanted, unplanned for, only child of Polish-born "neurotic" parents who never got along and who separated when the patient was about 10. It had been remarked, since she was two, that she was "always frightened." She grew up feeling insecure; was hypersensitive and withdrawn; playing by herself. She became very dependent on her mother until she was 13, when, upon return from a girls' camp, she declared herself "independent" and refused to live with her mother. She had previously been in the habit of visiting her father, but she gave him up about this same time, because of his inquisitiveness about her mother's behavior, and jealousy. Her school record was good. Little was known about her psychosexually except for her attachment to her mother and her ambivalent attitude toward her father. In the girls' camp where she had stayed, she had observed homosexual activities by some of the girls, to which she reacted with fear and anxiety.

Her later difficulty had been indefinite in onset but was apparently gradual and related to pubertal changes. Her anxiety and her inability to adjust—either at home or in the community—

culminated in withdrawal from reality, necessitating her first hospitalization. In the hospital, she received combined physiological and psychological therapies. She improved and was discharged. However, she failed to adjust, relapsed and had to be re-hospitalized (her second admission).

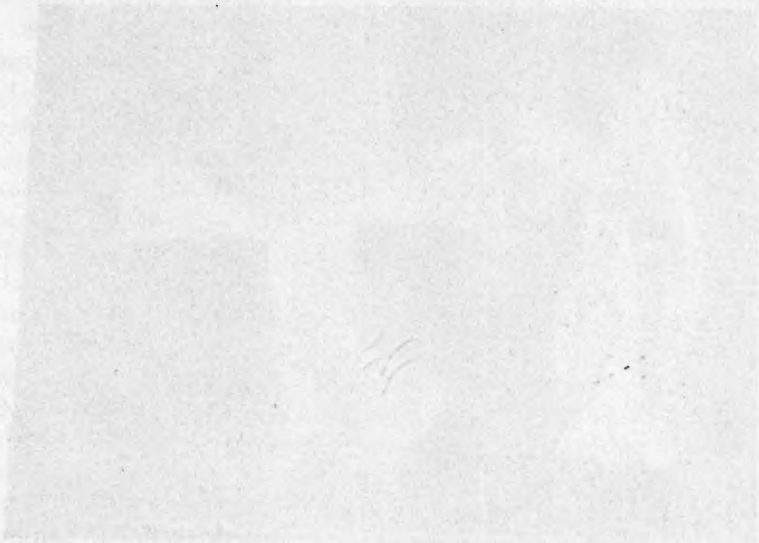
She was found to be in excellent physical condition. Her mental reaction was of the catatonic type. She again received combined therapy, with alternating states of improvement and withdrawal.

She applied herself well in the art classes and, when feeling better, would say that "art helps me to stand on my own feet." Her art production revealed some interesting points. Her favorite color was *yellow* which was related to the sun and warmth. *Purple* expressed fearful and awesome things. A certain type of *red,* the color of blood, was used for sexual identification. For instance, certain productions could be identified readily as being painted during menstruation. She painted a house flooded with the color described; and she also painted a dream of an Indian, on a red horse, who was chasing her (myth of the night fiend). Again, she painted a red boat with a blue sail. One interesting painting was of the "Garden of Eden," a version in purple depicting a fearful, if not awesome, state, and another version in red after the "Fall." Her transference was shown in a drawing of herself, along with a statue (catatonic state), with a magician (the psychiatrist) bringing her back to life (Figure 5).

Her relationship with her mother was pictured as "eating a lobster together," clearly suggestive of her libidinous relationship to the mother. There were also indications of death wishes against the mother; and both homosexual and heterosexual wishes were naïvely expressed. Regressive feelings were portrayed in the form of toilet scenes. Progress was shown by way of approaching her sexual problems more adequately. In the beginning, she pictured herself on the run from sex. Later she was apparently seeking it.

This case of schizophrenia offers interesting data. *Tactile* value was well presented in form and movement. The content suggested striving for interpersonal relationships. *Visceral* value was also well expressed. "Warm" colors were used. In states of "withdrawal," pigment was used in moderation. In "remission," the use of pigment was accentuated. There was an increase in the use of pigment under the influence of male companionship (a

Figure 5. This patient (Case 4) drew herself as a girl standing in front of a statue—symbolizing catatonia—with the central figure of the therapist, in the guise of a magician, treating her. The stage setting is golden yellow, which the patient considered a warm and cheerful color; she is dressed in white; the magician's robe is blue and white, with a rose panel in front and a rose hat. The whole painting shows her positive transference.



fellow-participant in the art classes), as well as during "psychophysiological" states, such as menstrual periods. *Respiratory* value suffered during states of withdrawal. At other times "organization of space" was satisfactory. The findings suggested a good affective "reservoir" in cases of this type, which, in turn, suggests greater possibility for rehabilitating them than is found in other forms of schizophrenic reaction. This is in harmony with clinical experience besides.

Summary and Conclusions

Thirty cases were studied at Manhattan (N.Y.) State Hospital to determine the relationship of art and psychotherapy to the total configuration of each case. A "psychophysiological" method was devised and is discussed in this paper, to evaluate the relationship. The following pertinent points of the study may be emphasized:

In total personality make up, homosexuality was found to be a prevalent trait, irrespective of psychiatric classification.

It was noted that—irrespective of psychiatric classification—the patients applied themselves rather well to art. They were highly productive, and they enjoyed the activity. On the interpretive side one may say that the art work helped in the release of aggression, in gratification by achievement, and in gaining in self-esteem.

The accomplishments of patients, disregarding artistry, were indicative of the expression of their *psychic* needs. The degree of expression of such needs mirrored the degree of preservation or disorganization of the total personality. This indication, in turn, was helpful diagnostically, as well as prognostically.

It may be stressed that, in schizophrenia, there was no evidence in the majority of cases of particular impairment of conceptual thinking. The patients were well able to execute plans of action. Another point is that the majority of cases of schizophrenia did not show any impairment of the relative constancy of the external *milieu*. A case of schizophrenia that showed severe disturbance of conceptual thinking, as well as disturbance of the relative constancy of the external environment, has been reported separately. In that case, an organic factor was considered to be present.

Finally, it may be said that art is helpful in both individual and group therapy. Art may be made an integral part of a

combined psychiatric therapy project, and as such is definitely recommended.

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BIBLIOGRAPHY

Annan, D.: Clinical aspects of combined psychiatric treatment. Am. J. Psychiat., III:734, 1953.

Berenson, B.: Aesthetics and History. Pantheon Books. New York. 1948.

Bergson, H.: Two Sources of Morality and Religion. Henry Holt. New York. 1935.

Davidson, G. M.: The final common path of the total personality. PSYCHIAT. QUART., 18:459, 1944.

Davidson, G. M.: Concerning hallucinations of smell. PSYCHIAT. QUART., 12:253, 1938.

Davidson, G. M. and Wise, B. V.: The relative constancy of the external environment in schizophrenia. J.N.M.D., 122:395, 1955.

Gabo, N.: On constructive realism. In: Three Lectures on Modern Art. Philosophical Library. New York. 1954.

Jones, E.: On the Nightmare. Liveright. New York. 1951.

Linton, R.: The Cultural Background of the Personality. Appleton-Century. New York. 1945.

Read, H.: The Meaning of Art. Pelican Books. 1950.

Read, H.: The Icon and Idea. Harvard University Press. 1955.

Suttie, I. D.: The Origin of Love and Hate. Kegan Paul, Trench, Trubner & Co. London. 1935.

LITERATURE AND EMPATHY: AN EXAMPLE

BY SYLVIA Z. FINKELSTEIN, M.A.

It is widely recognized that artists with universal appeal consciously or unconsciously grasp and depict common denominators of experience present in feelings, fantasies, and wishes which underlie human motivation and behavior. Freud,[1, 2, 3] Jones,[4] and others[5, 6, 7, 8] draw freely upon literary classics in formulating and illustrating theory. The theorists and clinicians often utilize artists and fictional characters as educational case-study material prototypical of certain richly endowed personalities, not ordinarily encountered in our clinical experience. This paper attempts to illustrate how literature also provides an experiential dimension by involving the reader as a direct participant in a character's situation through the mechanism of identification.* *The Catcher in the Rye*,[9] a story of a lonely, hypersensitive adolescent who finally experiences a psychotic episode, will be used extensively in this paper as illustration.

When an author facilitates our identification with a character within the safe confines of a book's limited context and definite boundaries, we can then frequently extend ourselves and learn what it is like to be in the shoes of a person who is experiencing a given emotional shock, mental state, or mood. This is often the closest we can get to knowing certain distant or deviant individuals and their feelings, as they are inside their skins. Such extensions in experience can be especially profitable for therapists, for emotional experience is the stuff of which empathic capacity is made; and empathy, as writers since Sullivan have stressed, is salient in any psychotherapeutic effort. The ease with which identification with a character is made often depends, among other factors, on:

1. The extent to which the reader can respond as though he has had or is potentially capable of identical or related experience.

2. The extent to which the character represents an emotionally intense experience for the author, the feelings involved pressing for release.

3. The extent to which the author is capable of pouring the feel-

*Freud discusses the manner in which this is facilitated, especially in the theater. See: Freud, S.: Psychopathic characters on the stage. Psychoan. Quart., 11:459-464, 1942.

ings involved into contextual molds of such dimensions and flexibility as to contain them in their dynamic form and to communicate them dynamically.

Just as people differ in their predispositions to, or guardedness against, experiencing given feelings and fantasies, so will they differ in what they select and derive from literature. Recollections of a related experience (fantasied or actual), stirred in the reader by a character, serve to provide a frame of reference for assimilating the fictional experience. Here assimilating requires that the fictional experience be added to, not substituted for, the affectively-related real experience that it echoes. Whereas the reader's experience, as subjectively felt or recalled, might be hazy or loosely-integrated, his re-living it through fiction can now encompass the additional facets and objectification presented by the new or repeated context. The reader's associations, along with the hero and his situation, are now the more readily externalized, are intellectually abstracted, and can provide a base for grasping another individual's communication of similar experience.*

A reader often identifies with characters who reflect feelings which he has repressed. The fictional form permits the reader to keep the character at a safe distance,** to accept insights in whatever doses are tolerable, and still maintain the repression. This assists the identification process, facilitating emotional participation without the reader being necessarily aware that the characterization represents aspects of himself. Note, for example, the reaction of many persons to stories of murder and incest. Note the popularity of writers like Mickey Spillane who tease the unconscious with tales of sadism and omnipotence. Our feelings and wishes, conscious or repressed, predispose us to experience infinitely more than we are permitted to experience, or are exposed to, by social sanctions. Goethe once said that he had never heard of a crime of which he did not regard himself capable.[10] Much of the awakened emotional response is retained in accessible recollections, which make it useful in therapeutic endeavors.

Authors whose works become classics succeed in communicating the essence of human nature so that we often encounter our

*Some projection undoubtedly occurs here. As Theodore Reik has phrased it in *Listening with the Third Ear* (Farrar, Straus, New York, 1949, p. 471): "Projection enables us to become aware of our feelings displaced onto the other person."

**This is discussed extensively by Simon O. Lesser in "The functions of form in narrative art." Psychiatry, 18:55-63, February 1955.

own potential selves in their characters and try on their experiences. Such authors are never mere observers or reporters of life. Through his capacity for empathy, for vivid fantasy and its actualization through writing, the author first experiences, then abstracts, then communicates the essential. Regardless of whether the content is realistic, the feelings involved are universally human and are intuitively grasped by the reader as plausible. Dostoevsky seems to experience and communicate in this fashion, perhaps because of his conscious intensification of all subjective experience, a tendency which he attributed to epilepsy and to his fear of imminent "insanity" and death. Fritz Peters authentically draws the schizophrenic and communicates this picture to the reader, because he can analyze, integrate, and objectify his own psychotic experiences with the self-searching efforts of one who desperately strives to attain and maintain sanity; Faulkner shares his characters' subjective experiences and stirs the readers to do so, perhaps because of a propensity for guilt, his empathy with the wronged, and the resulting personal assumption of social responsibility, which makes the Southern Negro's tortures his tortures. Examples abound.[11, 12] The writer will draw upon here as already stated, the contemporary, *The Catcher in the Rye,* a novel about a boy, Holden Caulfield, who, emotionally and in his reality-testing, reacts chronically as most people react only occasionally, when they are upset.

One of the conditions expediting identification involves, as said before, literary skills; the ability of the author to select essential behavior and translate it into stimulants to our senses and feelings. The following are examples of a few techniques which Salinger employs. Holden acts and feels with relatively little abstracting or pondering. He communicates with the novel's readers affectively, and directly, through his conversational, subjective accounts, facilitated by the first-person narrative form. He talks characteristically in images, visual, auditory, and others. For example, when he sees two people, barely acquainted, greet one another with a profusion of warmth, he is repelled by the false display, and remarks, "You'd have thought they'd taken baths together...when they were little kids. ... Old Buddyroos! ... slobbering around. Probably they had just met once, at some phony party." After being expelled from school, he had to visit

his teacher who seemed to Holden pitifully old and decrepit in his pajamas and with his cold. "All of a sudden I wanted to get out. ... I could feel a terrific lecture coming on. I didn't mind the idea so much, but I didn't feel like being lectured to and smell Vicks Nose Drops and look at Old Spencer in his pajamas ... all at the same time."

When he elaborates on feelings and thoughts he does so with analogies in terms of associated images. For example, when he carefully hangs up the dress of the prostitute, hardly older than himself, he feels sad. He elaborates, "I thought of her going in a store and buying it and nobody in the store knowing she was a prostitute at all. The salesman just thought she was a regular girl. ... It made me sad as hell." A certain pathos over her not being what she seemed and, but for circumstances and her insufficiencies, could be, is communicated to the reader. As in most affect-laden and image-laden communication, words drop their formal meanings, and only their connotations remain for the reader. Hence, the direct access to the character.

Repetitions, or, at best, not too distant concrete analogies serve almost exclusively as Holden's means of explaining things. He explains why he and a former roommate had to split up despite their liking for one another: his roommate had cheaper suitcases, scoffed at Holden's expensive ones, yet wanted people to believe that Holden's suitcases were his. Holden sums up and abstracts from the conflict: "It's really hard to be roommates with people if your suitcases are much better than theirs." Holden's concrete restating, instead of explaining, an idea or action suggests: his hopeful assumption that you cannot translate it into anything more elemental than what he has already stated; and/or that the meaning eludes him, defying verbalization and making him wary of self-committal on the matter; and/or the also hopeful assumption that others' frames of reference are identical with his, rendering elaboration superfluous.

Repetition also serves to suggest a feeling of incredulity and effort at holding on to the elusive. About the sister: "She likes me a lot ... She's quite fond of me. She really is." Throughout, repetition functions, as Freud indicates "as an excellent means to indicate the affective accentuation."[13]

Holden talks in the vernacular of the adolescent, but at times uses it to such excess and so indiscriminantly as to betray his

strained, not wholly successful, efforts to fit in with his peer group, e.g., "I was getting excited as hell ... and I took old goddamn Sally's hand. What a goddamn fool I was."

Another condition for identification involves similarities between the character and the reader. It is pertinent to note here that this character is unusually likable, perhaps because he is gentle and protective and couches his hostility in such piquant humor as to render us sufficiently undefended against seeing ourselves in him. It is then that we can empathically see Holden as he unawaredly reveals himself.

He is a lonely, guilt-ridden adolescent, a veritable instrument for registering others' feelings, vulnerabilities, and defenses. Through his own depression, he suffers for their hurts and deprivations, which he senses and embroiders or projects wholly. He cannot permit himself the overt expression of the hostile and, above all, of the tender feelings that overwhelm him. And with studied abandon he attempts to hide his gentle protectiveness of others, his child-like needs for closeness with someone and the desire for a cause in which to lose himself. That is, he attempts to hide these feelings except when he is in the company of carefree children or, as he sees them, not yet corrupted human beings. He is distant from his parents, in fact, from all adults. His father is to him the successful man who is forever busy with that which is expedient. His mother must be avoided, for she has been hurt enough. He runs also from his teacher who shows him kindness and affection, but whose tenderness seems contaminated with perversion and is to be distrusted. Holden's entire world is made up of striving, competitive selfish "phonies" and persons that are to be pitied. The former stimulate him to anger and withdrawal, the latter to sadness and to childish dreams of being their rescuer. He hovers between the two groups, lacking in any stable identity or purpose. Finally, he goes into a panic over his aimless drifting, his loneliness, and his uncertainty as to the value of anything. As doubtful anchors and sources of support, he has only his devoted sister—who is a child, and to whom he can relate —and his dead little brother who is a magical helper.

Holden touches on much that his readers can recall. Among them are those who were early bereft of close adults, and who have had to renounce childhood prematurely, regretfully burning their bridges to still sorely needed dependency. All of us,

as adolescents, have had to grope to some degree for meanings and constants among the values held by adults who were important to us. And, like Holden, many of us were frightened when those who once seemed sturdy oaks wavered and changed beyond our comprehension.

Who has not experienced a moment when he has been shocked into awareness that he was at the brink of a transition between one stage of maturity and another, as is Holden? At such times the characteristic *Gestalt* one presents to others and that which constitutes one's self-concept seems no longer appropriate. Formerly satisfying old reliables in social techniques have to be relinquished. There is a sense of loss and regret over wasted opportunities. In their place, there is little that has been tried and proved. Yet there is shame, and feelings of futility over tenacious clinging to the outmoded. A casting about seems necessary, with unknown, perhaps feared, consequences. In the basically insecure, in the rigid, in one who is distant—with tenuous identification or a limited feeling of belonging with peers with whom to share the experience—such a time can be painful.

In the adolescent—in whom, in addition to inexperience, there is an awakening of feelings and needs often beyond his control, comprehension, or powers to gratify—such an experience can be traumatic. In one, like Holden, who is, or recalls having been, both alone and in the grip of unfamiliar feelings, such a period can be subjectively devastating. At such a time, one must not seem serious or set in his experimentally-adopted techniques, or there will be no backtracking and no escape from derision in case of error. And yet one must seem set and certain, so as to appear adult and invulnerable; one must be cautious in exhibiting feelings lest greenness show, yet feelings run high and clamor for release. Hence, as in Holden, there can be the endless kidding around, the posing and other disguised testing, the aborted or noncommittal attempts at explaining, and the momentarily believed-in outbursts of heterosexual bravado—executed "suave as hell."

From this base of similar experience, where identification with Holden is possible, the reader can conjecture how it must feel to be a hypersenitive adolescent who lacks a feeling of belonging with family and peers, is convinced he is a failure, and is disillusioned in the adults who could otherwise serve as models or sup-

ports. The differences in feeling between Holden and the readers about him are in its frequency, intensity, or persistence.

Summary

Literature can provide an experimental dimension by stimulating identification with its characters. Such extension of experience can be valuable for psychologists and therapy trainees. Readers differ in what they select and derive from literature, in accordance with their openness for, or guardedness against, feelings and fantasies that the characters express. For identification to occur, certain conditions must be present in the writer, in the writing, in the character and in the reader. Salinger's *Catcher in the Rye* is used to illustrate this thesis.

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References

1. Freud, Sigmund: The Interpretation of Dreams. (1900.) In: The Basic Writings of Sigmund Freud. A. A. Brill, editor. P. 308. Random House. New York. 1938.
2. ——: Dostoevsky and parricide. (1928.) In: Collected Papers. James Strachey, editor. Vol. V. London. Hogarth Press. 1952.
3. ——: Leonardo Da Vinci. Translated by A. A. Brill. Random House. New York. 1947.
4. Jones, Ernest: Hamlet and Oedipus. Norton. New York. 1949.
5. Reik, Theodor: The Secret Self. Farrar, Straus and Young. New York. 1953.
6. Daley, C. D.: The mother complex in literature. In: Yearbook of Psychoanalysis. Vol. 4, 1948. P. 172. International Universities Press. New York. 1949.
7. Bychowski, G.: Walt Whitman, a study in sublimation. In: Psychoanalysis and Social Sciences. Vol. 3, pp. 223-261. International Universities Press. New York. 1951.
8. Kucera, O.: The mechanisms of regression in the poetry of Baudelaire and his followers. Int. J. Psychoan., 31:98, 1950.
9. Salinger, J. D.: The Catcher in the Rye. Little, Brown. Boston. 1945.
10. Goethe, J. W.: Quoted by Mann, Thomas: Preface to The Short Novels of Dostoevsky. P. 9. Dial. 1949.
11. Lemon, E.: Reader's Guide to Prose and Fiction. Appleton-Century. New York. 1940.
12. Shrodes, C.; Van Grundy, J., and Husband, R. W. (editors): Psychology Through Literature: An Anthology. Oxford University Press. New York. 1943.
13. Ref. 3, p. 98.

GROUP THERAPY AS AN AID WITH DELINQUENT PUBESCENTS IN A SPECIAL PUBLIC SCHOOL*

BY HENRY I. SCHNEER, M.D., HARRY GOTTESFELD, Ph.D., AND ABRAHAM SALES, M.A.

Delinquency is used in this paper in the descriptive sense of "character determined uncooperativeness or dissocial attitudes"[1] among intellectually and educationally retarded male pubescents with various generically determined severe emotional disorders.

In teaching such pubescents, special problems are posed. For instance, classroom arrangements, time requirements, and size of class should be modified from the normal standards. A branch of the public school system of New York City known as the "600 school" has, therefore, been developed. Children whose behavior is disruptive or withdrawn in regular school classes can be transferred to a 600 school through the Bureau of Child Guidance or other agencies. The aim of these schools as an education system is to initate processes by which the child can be restored to a regular school, or by which the child can acquire enough skills to hold a job. The processes function concurrently. If restitutive efforts fail, a child may be certified to a state hospital.

Public School 612 was established in 1947 in the psychiatric division of Kings County Hospital, Brooklyn. At first it was only a school for in-patient ward children; but the educational service was extended in 1949 to out-patient children (ages four to 16) who previously had been ward patients. A short time later the school was made available to all children in the age group.

The classes never exceed nine pupils; much remedial work is done; and formal censure and disciplinary actions are kept to a minimum by very devoted teachers with high frustration tolerance. Despite these differences, the organization is along the lines of a regular school. Effort is stressed in the direction of steadily developing a child's capacity to re-adapt to the regular school environment.

To facilitate adaptation to an ordinary school—as if P.S. 612 were an ordinary school—group therapy was undertaken. Its aim was to keep the children's emotional disturbances centered in a

*This paper is written, in collaboration, by a psychiatrist on the faculty of the State University of New York College of Medicine, a staff psychologist of Kings County Hospital, and the principal of P.S. 612, a "rehabilitation" school in New York City.

group for therapy, while, as members of their groups in the classroom, the children could pursue the learning process more formally. A professional therapist led the group. While it is true that each teacher, through a good relationship with the children, acts as a therapeutic agent, the primary purpose of the teacher is the educational progress of the child. The use of a therapist not connected with the school allows for a focus on the emotional difficulties of the children and provides a feeling that the group therapy project is a treatment program.

A therapy group made up of boys was projected in January 1955. Their parents were not—and could not be—brought into a concurrent therapy group. Other therapy groups, in which parents were also in therapy, will be reported in a later paper.

Group therapists were drawn from the psychiatric division of Kings County Hospital and consisted of psychologists, social workers and psychiatrists. In the group reported here, the therapist was a psychologist supervised by a psychiatrist. The therapists held conferences with members of the educational and psychiatric staffs.

Composition of the Therapy Group

Five boys and a man therapist have been meeting once a week during the school year. This report covers approximately one and one-half years of the group's existence.

Certain characteristics are common to the five boys, aged from 10 to 12. All have demonstrated aggressive, non-conforming behavior in school. All are both intellectually and educationally retarded. Their verbal facility is poor. Typically, they act out their problems. They come from homes that are economically and emotionally impoverished. All of them belong to large families in which one or both parents are missing or are extremely inadequate—examples of the "problem family" which has been getting newspaper publicity recently.[2] The racial and national background of the group was varied; two of the boys were Negroes, one was French-Canadian, one was Jewish, one Puerto-Rican.

A therapeutic technique approximating an activity group was found necessary. The ideal of establishing group balance by selecting opposites, as recommended by Slavson for activity group therapy, was not altogether realizable, as all members acted more or less aggressively. Interaction with each other and with the

therapist, especially where it might elicit verbalization, was encouraged through sports, games, fantasy-play acting and a "feeding" situation.

Where pertinent and possible, attempts were made by the therapist to explain and assuage frustration in relationships. The group members were told that physical hurts to each other would be stopped. The therapist was a firm, friendly, authority figure who attempted to structure the therapeutic situation so that maximum satisfactions were possible in a permissive atmosphere which, however, did not sanction destructiveness.[3] It was important that the children gain a sense of belonging and identity with this group, since there existed little opportunity for them to be accepted in any group. They were rejected at regular schools, and rejection or neglect was the typical pattern of the home. The sharing of responsibilities here, such as the making of group decisions, was encouraged so as to develop pride in the group. The boys were told that they were in P.S. 612 because they could not get along and learn well enough in regular school, and that the purpose of the group was to help them get back to regular school.

The boys were Tommy, James, Lucius, Miguel and Dan.

Tommy, 11, thin, delicate, was admitted to P.S. 612 because he was completely unmanageable in school. He would walk around the classroom and precipitate fights. He also stole things from his playmates and from neighborhood stores. Tommy's difficulties were first noticed when at seven, following a year and a half away at a parochial school, he began to show marked feminine behavior. He seemed interested in feminine activities only and spent most of his time cooking and doing housework.

When Tommy was 10 his mother found out that he performed fellatio with an older cousin. Tommy lives in a six-room "railroad" flat and has nine siblings. Although he is closely attached to his mother, she feels that she has little time to devote to him and that he is often a nuisance around the house. One day, she brought him to school and said she did not want to take him home. She would leave Tommy with the police department if the school authorities did not take care of him. She was finally persuaded to take him home, but, on subsequent occasions, she called the police to take Tommy away. Tommy's I.Q. is 91; his reading is on the third grade level and his ability to solve arithmetical problems on the fourth grade level. Other aspects of the psychological examination

suggested the possibility of a thinking-disorder and paranoid mechanisms.

James, a tall, thin, generally uncommunicative, Negro boy looking younger than his actual age, was referred to P.S. 612 for chronic truancy. When any adult at school had attempted to speak to him he had run away. His teachers described him as "withdrawn, nonparticipating." James had been picked up by the police, charged—with two other boys—with assaulting, and stealing a pocketbook from, a woman. James comes from a poverty-stricken home and lives in a cellar in a cold water flat. The parents were named on a "neglect petition."*

James has 10 brothers, some of whom have a history of stealing, truancy and running away. One is being held on a charge of homicide which was said to have occurred in the presence of James. James' father is frequently drunk and abusive, and assumes little responsibility in the home. He often questions his wife as to whether all the children are his. James' mother has been described as a very immature and dependent person. Before a charitable fund clothed James, he was found barefooted and without a coat. James' I.Q. is 75; and his school work is at the third grade level. Other psychological testing reveals a problem in impulse-control and in regression to the point of disorganization. James is 12 years old.

Lucius is a Negro boy of average size. He was unable to get along in an ordinary school setting because of continued impulsive, aggressive behavior. He became restless, aggressive and enuretic following the death, six years before, of his grandmother, who had acted as a strong unifying force in the family and to whom Lucius was closely attached. At present Lucius' father and mother are separated. He has six siblings, three of whom are in a state school for mental defectives. His mother states: "I had them sent there because they weren't doing so hot in school and I couldn't take care of them." His youngest sibling was fathered by his mother's "boyfriend." The neighborhood where Lucius lives is very poor with no recreational facilities. He is severely retarded educationally, his reading and arithmetic being only at the first grade level. His I.Q. is 67; he is 11 years old.

Miguel is a chubby boy of Puerto Rican family, one of seven children. At school he had been very aggressive to teachers and

*Petition brought in court by official city agency against parents.

students. In a fight he injured a boy by hitting him in the ear, which resulted in his being brought to court. Miguel was sent to Kings County Hospital for observation as to the possibility of a schizophrenic process. It was noted that he walked along the corridor with his face and hands to the wall. Miguel's father is now in jail because he stabbed the father of a boy who was involved in a fight with Miguel. Miguel's mother is a primitive, dull woman who does not know any reason why Miguel should attend a school for emotionally disturbed children. She feels that Miguel is a good boy who has to some extent taken the place of her husband in that he helps her take care of the other children. Miguel's I.Q. is 83. He shows no willingness to learn. Practically, he is a non-reader. He is 11 years old.

Dan, 10, is small and stocky; his school adjustment has been very poor. His I.Q. is 83. He has frequently truanted and once, while in the third grade, stood on the window sill and stated that he was going to jump off. He performed pranks, such as going under the teacher's desk and tickling the teacher's feet. The Jewish Family Service sent him to Edenwald (a residential "600-type" school). After returning from there he was described as quiet and shy, watching television most of the time.

Dan has five siblings. The family of eight occupied four rooms. There was no privacy and much marital discord. Dan's mother felt that the family difficulties stemmed from having a small apartment; she finally obtained a larger one, and friction in the family diminished. Dan's father is unemployed. He has never held a steady job. He frequently becomes enraged at small incidents.

While all of the families described were economically and emotionally impoverished, and neglect and rejection were common patterns, it was felt that James' and Tommy's family backgrounds were the most seriously pathological. In James' case, extreme poverty, disorganization, murder, incest, and stealing were accepted ways of life. No other mother of a boy in the group was so openly rejecting as Tommy's. She made it obvious she did not want Tommy as a family member. In Miguel's case, familial closeness is shown in Miguel's father going to his aid in a neighborhood fight and in his mother's frequent praise of him. Lucius benefited from a close relationship with his grandmother during his early years. Dan's family is on a somewhat higher economic

plane than are the other families. Dan's mother's successful attempts to find larger quarters suggest an active concern with bettering conditions for her family.

Typical Group Therapy Session

A group session, illustrative of the trends of each of the boys and the technique of the group therapy, is presented. There was a total of 42 such sessions.

Group Session No. 17. When the therapist arrived at the end of the school day, the children were in a tumult. Lucius and Dan were pushing a cart down a corridor with shouts. Tommy and Miguel yelled, "Let's go, Doc." The therapist took them downstairs to the gymnasium. While he was opening the door Lucius and Miguel began to punch each other. The therapist separated them and inquired what the fight was about. He asked the group to gather around to see what the trouble was. James said, "It's nothing, Doc," and the rest of the group ran into the gymnasium and began to play with some basketballs that were lying on the floor.

Jimmy, a day school child who belonged to another therapy group, was at the far end of the gym, and the therapist told him that the gym was available now only for the group and that he would have to leave. Jimmy took his time about leaving and the boys of the group yelled at him until he left.

Lucius asked the therapist to play pool. Dan then asked the therapist to play pool with him. Lucius said that Dan had "asked second," so he should not play. The therapist suggested that the whole group play, but Lucius went off to a corner of the gym and began to play by himself with a bat and ball while Dan smiled smugly at having Lucius out of the way.

Tommy said that he was going to dance the way the girls did upstairs; and, with exaggerated feminine gestures, he began to prance about. Lucius grabbed Tommy, and they began to wrestle playfully on the floor. Lucius said with a broad smile "He's hurting me, Doc." The therapist said jokingly that this was the first time he had seen someone laughing who was hurt. The therapist said that Lucius was a good pitcher and suggested a baseball game. The group agreed, and the therapist acted as umpire.

For a while there was uninterrupted play. Then James reached into Miguel's pocket, took his wallet and ran across the gym, with Miguel in pursuit, and crying. The therapist said, "C'mon James,

give it back." James threw the wallet at Miguel and began to walk out of the gym. The therapist said, "C'mon back James. Let's talk this over." James turned, said to the therapist, "You louse," and continued on his way. The therapist said, "You're leaving because you can't take it." Despite this, James left the gym.

Miguel announced that it was time for chocolate milk and cookies. The therapist asked whom the children wanted in charge of distributing the milk and cookies. Lucius said, "Me." Tommy said, "Me, milk: Lucius, cookies." Dan said, "Tommy, milk; me, cookies." Miguel was silent and the therapist asked him whom he wanted. He replied, "I don't care." Lucius and Tommy, having obtained the most votes, were given charge of a box of cookies and a pitcher of chocolate milk. Tommy gave each child and the therapist a cup of milk. Lucius gave only Tommy a couple of crackers and kept the rest for himself. Miguel complained to the therapist that Lucius did not give him any of the cookies.

The therapist told Miguel that Lucius had been elected to be in charge of cookies and could do what he wanted with them. However, there would be another vote next week; and, if Miguel felt that he did not like the way Lucius had given out the cookies, he could vote for someone else. Lucius, who had been listening to this conversation, then began to distribute cookies to each child.

Miguel asked the therapist, "Where does this milk come from?" The therapist asked the group what they thought. Dan said, "The hospital gives it to us." The therapist inquired, "Well, where does it come from before it comes to the hospital?" Tommy said "It comes from cows, but some milk comes from ladies." Dan and Lucius began to giggle. At this time several people came into the gym as the therapy hour was over. The therapist said "If you want to, we can continue talking about this next time."

Discussion of Group Therapy Session

The problem pattern of each boy was clearly delineated and quickly reflected in the group therapy session. For example, Lucius' difficulty in controlling aggression; Tommy's sexual conflict; James' wallet-snatching and inability to sustain an object relationship; Miguel's isolation and being taken for a scapegoat; and Dan's passivity but connivance were all in evidence.

In-group feeling was strong, as was shown by the group's oust-

ing of Jimmy, a non-member. Pride in the group often took on a hostile, characteristic quality as, "We have the best group... Our group challenges any other group... Our doctor could beat up the doctor of the Monday group."

Nevertheless, as shown in this session, the therapist's attempts to elicit verbalization in reaction to incidents involving fighting and stealing were usually met with rebuffs. The boys come to the group with established sadomasochistic patterns of relationship, almost refractory to verbalization. Relationships were mainly at the level of action. Also, the apparent code was that if you are hit by another boy you "don't squeal." As to the incident of James' taking Miguel's wallet, it behooved the therapist to intervene—since the promise of protection had been given to the boys from the beginning. Perhaps other ways of handling the situation might have been more effective in keeping James in the group so as to develop his group tie, and consequently develop his conscience. James' group life (family life) however, was characterized by grasping for survival. Perhaps if the return of the wallet to the "hollering," crying Miguel, had been accompanied by gratifying James' grasping impulse by giving him a substitute material object, there then might have been time to get the group together to firmly establish a rule regarding stealing from each other. Shulman's description of a delinquent girls' group discussion of stealing, however, indicated that "none of the girls seemed to feel that stealing was undesirable."[4]

By the twenty-seventh session, there were further developments in the group. Lucius had a closer relationship with the therapist. He organized games and assigned players. He seemed to enjoy playful talk and a show of physical prowess. He felt that his seniority and size entitled him to special privileges such as reprimanding another boy who did something he considered wrong. Distorted, uncontrollable aggressive behavior decreased generally.

James would criticize the therapist for evoking sexual discussion. "Doc, why do you talk about those dirty things?" His attendance was irregular; he would be "out sick"; and he was the member who was furthest out on the periphery of the group.

Tommy readily followed Lucius and appeared to derive some ego support from him. Each would go to the aid of the other in any threatened fight.

Miguel steadily found more acceptance. Nevertheless, he still

tended to play by himself and required some encouragement to participate in the group games. He frequently inquired about the time for milk and cookies and ate voraciously every time.

Dan acted out his impulses more openly. He pulled the fire alarm, flooded the toilets, spat into and spilled out the milk.

The milk-feeding period toward the end of the session proved to be an excellent opportunity for the therapist to stimulate discussions about birth, development, family, sex, school and social relationships. For instance, talk about milk led to talk about "tits." Dan would refer to the breasts as "fucking tits," expressing a crudely resentful attitude toward an inadequate mother whom he had had to share with five siblings. He was also indicating, psychodynamically, a part-object identification with this powerful aspect (the breast) of the mother. It was not the mother as a person whom he recognized, but this succoring aspect of her. As was just noted—and as a matter that reaffirmed his difficulty in object relations with his mother and its implications for early ego development—this same boy repeatedly indulged in aggressive play with milk.

James, who came from a family of many siblings in which mother-son incest was strongly suspected, complained with disgust but still listened with interest, to the other boys' talk about sex. Sexual discussions allowed ventilation of dammed-up tension for these pubescent boys, who came from crowded habitats wherein the sexual activity of adults was omnipresent. Furthermore, that an adult would discuss such matters in an informed and explicit way was a matter that offered clarification of confusing and disturbing sexual thoughts, and relief from anxiety.

The milk-feeding time also provided an opportunity to elect "officials." These children never had had the chance of leadership by democratic decision. Their pattern had been to anticipate neglect or sadistic management by authority. Such authority usually would be dealt with by masochistically-determined defiance. Now, in this group, they were to a considerable extent their own authority with the opportunity to evolve other concepts of authority. For example, the boy elected to give out milk was responsible for seeing that all members shared equally.

Lucius and Tommy, elected as officials during the early sessions, engaged in a withholding and giving game at first. The group clamored, threatening to depose them by election, and Lucius and

Tommy desisted. When these three other impulsive, aggressive boys did not strike out at Tommy and Lucius but reacted in a non-violent manner to the frustration—and received consequent gratification in this different mode of behavior—the basis for more effective behavioral patterns and for super-ego formation was being laid. Humorous attempts to corrupt the idea of, "Let's vote on it," were frequently made; but, far from carrying it to an absurdity, the serious impact of this idea seemed to be realized by all the boys.

Role playing proved to be a valuable technique. For example a school game would be played where the classroom would be imitated and abreaction in regard to the principal and teachers would be encouraged. Attitudes about school came easily to the fore. James, playing the role of a teacher, ordered the other children about in a dictatorial manner. Lucius insisted on playing the part of a principal and asked the therapist to be a student. The therapist agreed to this and Lucius asked questions and gave directions to the therapist in a firm but kindly manner. The therapist later asked the other boys what they thought of the way James and Lucius played their roles. Agreements and disagreements about this followed, and the boys were able to compare their attitudes toward school authorities. Also this provided an opportunity for the children to empathize concretely with authority figures—which, in their development of conscience, had been incompletely and distortedly incorporated.

A consistent observation throughout most of the sessions was that the boys sought individual attention from the therapist. Each would attempt to individualize the therapy. Lucius, for instance, would say, "Read the comic book to me. You read this to me." To these children, all of whom came from large families, the group situation probably seemed similar to their family situations in which they were involved in strenuous competition for the attention of their parents.

Academic Progress and Emotional Adjustment in School

The effects of the therapy on these boys' school records differed markedly. James made some progress academically, but this was limited by his frequent absences. In school, there seemed to be little improvement in his social behavior and emotional reactions. He was alternately taciturn, then verbally abusive and defiant.

He teased weaker children and attempted to manipulate the teachers to give him money. He once stole money from a woman who was collecting for charity. Several home visits were made by teachers who said his home conditions were "terrible" and that "the poverty defied description." The obstacle of home environment was thought to be overwhelming. During the summer, when school was out and therapy had temporarily ceased, James was caught stealing a car and sent to the New York State Training School for Boys.

Lucius' behavior changed noticeably while he was in therapy. His aggressive actions lessened considerably, and his teacher reported that he seemed much more amenable to direction. But, despite his improvement in the emotional, social sphere he made little progress academically. One teacher gave Lucius individual instruction in reading with little success. He would be attentive at first but soon lose interest. Lucius had a psychological examination, and the intelligence test findings indicated mild mental deficiency. It was the opinion of the teaching and psychiatric staff that the day school did not serve Lucius any longer and he was subsequently placed in a CRMD class* in a regular school.

Tommy showed little improvement in his personal, social development during the time he was in group therapy. Teachers reported that at first he seemed to be making some progress but then it was observed that he would wander through the halls, shouting inappropriately and generally upsetting the work of the children in the classrooms. His aggressive behavior seemed to have begun shortly after his mother had begun to speak openly to him and others of having him institutionalized. At this time Tommy frequently absented himself from group therapy sessions, and, when he did attend, he participated minimally.

Attempts to have Tommy talk about what was going on at home were met with tearful defiance. Group therapy did not help him deal with the tremendous negative emotional impact of a mother who blatantly rejected him. In school he subsequently made no academic progress. Nevertheless, it was observed that he did show some improvement in the sexual area. When Tommy first attended P.S. 612, he put on lipstick and dressed in women's shoes. After a while, he no longer did this, although he still made some feminine gestures. It was felt that group therapy had a direct bearing

*CRMD=Children with Retarded Mental Development.

on the modification of his feminine behavior, in that to gain acceptance in the group, he had to adopt some of the aggressive, boyish attitudes of the other members. In school, Tommy formed a close attachment to one of the men teachers and would stay close to him whenever he could. He left school when his family moved from the neighborhood. The family left no forwarding address.

Miguel showed marked improvement both academically and in his emotional reactions. Within a year and a half, he went from the second grade in reading and arithmetic to about the fourth grade. He was greatly gratified by his reading ability and would read to anyone who would listen. Also, he quieted down considerably and developed greater frustration tolerance. At first when other children teased Miguel he would become enraged and threaten to kill his tormentors. Later he became more tolerant of such attacks. For example, a child once put salt into Miguel's milk at lunch. Miguel calmly turned to the teacher and asked for another container.

With the development of greater frustration tolerance in school, there was a corresponding development in group therapy. At first Miguel felt himself to be alone and isolated in the group and he would react violently when other group members picked on him. As friendships with group members developed, Miguel felt himself to be accepted, was less threatened when some child teased or tormented him, and was able to react by either ignoring his tormentor or replying in kind. An important contributory factor in Miguel's emotional development was the warm attention of a teacher to whom Miguel became attached. Miguel will be sent to a regular school on a trial basis.

Dan made normal progress in school. He is now achieving at the fourth grade level in reading and mathematics. He is willing to attend to his lessons for reasonable lengths of time. He has been given certain responsibilities such as operating a 16 mm. movie projector and taking care of electrical equipment. Dan sometimes has tantrums in the classroom, but teachers in general report that these outbursts have become less frequent and less intense. However, occasionally, when difficulties arise at home, Dan is likely to become aggressive on slight provocation. Nevertheless, he now seems more amenable to classroom routine, and he has been recommended for regular school on a trial basis.

Discussion

The therapy group of delinquent pubescent boys reported herein was conducted on an extramural basis. They came from their homes to school and attended the therapy group after school hours. Slavson indicates that poor results are to be expected with such a group, and that treatment must come from the pressure of a planned authoritarian environment.[5] It would not be plausible to claim remarkably good results, just because three (Lucius, Miguel and Dan) out of five boys were being returned to regular school. Nevertheless the experience with the group has certain important implications. The individual pull for attention made the writers recognize that these delinquent pubescent boys would probably be treated more effectively by combined individual and group therapy. It also appeared that the extent of the boy's delinquency was not so important for treatment and restoration to a regular school as the pathology of the boy's family, specifically rejection, indifference and poverty. Ordinarily, intra-family bonds are strained at pubescence. With the boys reported here, the need for increased family-belonging is like the nurture required in a deficiency disease.

The therapy group in the milieu of a special school helped to return some of these pubescents to regular school because it had a neutralizing effect on the generally psychologically-destructive influences of their families. Beside the repetitious pattern of disruptive, rejecting, dissociative, sadistic and masochistic experiences of these children at home, counterbalancing, positive experiences were generated through the special school and the therapy group. The children had relationships with adults who provided nonpunitive, constructive leadership; they had the gratifications of acceptance and belonging; they had the freedom to ventilate emotionally charged impulses safely. These experiences resulted in a lessening of anxiety, improvement in over-all ego organization and an increasing ability to withstand external stresses. Consequently, return to the routine of the regular school was facilitated.

On the other hand, for the two boys of the experimental group who failed to return to the regular school, the deleterious, utterly rejecting attitudes of their families overwhelmed the positive influences of the group. It would appear that the extent and type

of family pathology would be a criterion in the selecting of delinquent pubescents who will profit from an extramural group therapy experience. In cases of extreme family pathology, intramural, authority-oriented group therapy, as described by Schulman and Slavson, is probably indicated.

Schulman carried out intramural group therapy for psychopaths.[6] He reported treatment of a group of delinquent adolescent girls, in which he aimed for an "authority-dependency transference" to achieve "a goal of repressing the instincts." He vested himself with authority by becoming the person to decide when the adolescents could leave the home, which was "as soon as they came to know themselves and could get along with people." The exertion of similar "pressure" or authority was not possible at the "600 school" because the circumstances of therapy were extramural; and, also, the incentive to leave the 600 school to go to a regular school was not always strong. It was mainly the shame, associated with being at a 600 school which was in a mental hospital, that provided the stimulus to get back to a regular school.

Buchmueller and Gildea's group therapy project with parents of behavior problem children in public schools indicated the improvement obtained in school work when the parents attended a discussion group.[7] The writers' impression from work with another group of boys from P.S. 612, where the parents were in a group concomitantly, is that the chance for restoration to a regular school would be much greater under such circumstances. It also seemed, however, that the boys were not so severely delinquent when the parents could be involved in a group. Their character disturbances would appear to be more neurotically or psychotically than delinquently involved. This would coincide with Peck and Bellsmith's suggestion that group therapy success with delinquent adolescents correlates positively with the extent of neurotic pathology and negatively with the extent of "psychopathy."

Conclusion

An extramural group therapy program for delinquent pubescents, in conjunction with a specially organized school for emotionally disturbed children, is described. On the basis of experiences with one therapy group, such a program seems promising in facilitating the children's return to regular school, but only

when the home environments are not altogether rejecting, indifferent or impoverished.

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REFERENCES

1. Schulman, I.: Chapter XI, Fields of Group Psychotherapy, S. R. Slavson, editor. International Universities Press. New York. 1956.
2. Samuels, G.: Plans to salvage the "problem family." New York Times Magazine, May 12, 1957.
3. Schiffer, M.: Permissiveness versus sanction in activity group therapy. Int. J. Group Psychother., II:3, July 1952.
4. Schulman: Op. cit.
5. Slavson, S. R.: The Practice of Group Therapy. Chapters IV, and V. International Universities Press. New York. 1947.
6. Schulman: Op. cit.
7. Buchmueller, A. D., and Gildea, Margaret C.-L.: A group therapy project with parents of behavior problem children in public schools. Am. J. Psychiat., July 1949.
8. Peck, H. B., and Bellsmith, V.: Treatment of the Delinquent Adolescent. Family Service Association. New York. 1954.

THE PSYCHOLOGICAL SIGNIFICANCE OF HOT RODS AND AUTOMOBILE DRIVING TO ADOLESCENT MALES*

BY I. HYMAN WEILAND, M.D.

Being able to drive, the kind of car driven, and the ways cars are driven, have, in recent years, become of paramount interest to adolescent boys, and the concern of the adult population. In many instances the family car is the center of conflict, especially between son and father.

There can be little doubt that the intense interest of the adolescent in these matters gratifies some need or needs peculiar to his age group. The intensity of the interest also suggests, not merely that the activity involving cars and driving satifies such age group needs, but rather that the automobile and its handling are probably exceptionally suitable sublimations for particularly important impulses in the adolescent male.

In an inquiry into preoccupation with cars and driving, eight male subjects, seven of whom were in psychotherapy, were studied. Four were definitely in the adolescent age group (13 to 19 years old). One was 20; and two were children. The eighth subject, an adult colleague of the author, reported experiences from observations on himself during adolescence and on others during young adulthood. The subjects were selected solely on the basis of their interest in automobiles and driving, and because they were known well as the result of all but one having been in psychotherapy at least six months.**

Because of the small number of subjects, no attempt will be made to determine universally-applicable reasons for interest in automobile driving among adolescents; rather, the material is presented to show some possible ways in which the automobile can be important to them, and to offer some suggestions as to why it has such tremendous importance. Any suggestions as to the universality of interest in cars are recognized as merely tentative. The method of investigation was to note attitudes about

*From the Eastern Pennsylvania Psychiatric Institute, Philadelphia, Pa. Read at the annual convention of the American Orthopsychiatric Association, Chicago, February 28 to March 2, 1955.

**All except one adolescent and the young adult were treated by this author. The material on the adolescent was obtained through the courtesy of Dr. I. Arthur Mirsky, and that of the young adult through the courtesy of Dr. C. Glenn Clements.

automobiles and driving—although they were not specifically asked for—during psychotherapeutic interviews. The psychotherapy could be characterized briefly as nondirective, expressive, and psychoanalytically oriented.

Following are presented brief summaries of the case histories studied, along with more detailed comments about the patients' interest in automobiles.

Case 1

A., a 16-year-old boy, was brought to psychiatric treatment by his parents because of a number of antisocial acts, failure in school, refusal to accept responsibility, disobedience, and because of A.'s own desire for help in overcoming feelings of personal inadequacy. He often related these feelings in part to being without an automobile. A. said he needed a car to be popular with the girls, and to be admired and accepted by the gang. Later, when he did obtain the use of an automobile—by taking it without his father's permission—he would spend much time trying to impress his boyfriends by racing, seeing who could make the sharpest turns, and "rough riding." During the course of therapy, the car was never used for "dating."

A.'s relationship with his father was characterized by a need to outwit him—taking things from him but not being able to accept them as worthwhile gifts. This was true in the case of the car, as well as in the case of other objects. Mother's car was larger and more attractive (a high-priced convertible) than the father's (a low-priced sedan), but the boy would "steal" only his father's car for his escapades. There were numerous rationalizations for not taking his mother's car; but none was particularly convincing, even to the patient. On the other hand, this boy would never ask his father for the car because of his unfounded conviction that he would be refused.

Each of the three times that A. ran away in his father's car, he was involved in an accident and picked up by the police before getting more than half way on his journey. Almost every time that he took the car without permission, he placed himself in serious danger of being arrested for some traffic violation; or he drove where his parents or his parent's friends might see him. He delighted in outwitting his parents and in letting them know they had been outwitted.

After A. had been in treatment about half a year, he recalled

that his feelings while racing in his father's car were similar to feelings he had had when, as a child, he had competed with other children to see who could urinate farthest or who had the largest penis. With some surprise, he then commented that he could never compete with his father's penis because it was much larger and "Father had much more experience using it."

Much of A.'s free time was spent in tinkering with a friend's "hot-rod," although there was little prospect of the two boys being able to get the car running. A frequent fantasy he had about cars was one in which he would obtain a "big black car with lots of chrome trimming," in which he could show off. He would then fantasy, however, that he would strip this car of all its chrome and paint the places where the chrome was removed. This boy was also interested in special attachments, all of which were to be hidden—especially from policemen who would frown on the special speed, etc., that the gadgets would offer.

Comment. A.'s attitudes about cars most clearly demonstrated his ambivalent desire for masculine status. His feeling that to obtain this power he must steal from his father was acted out by stealing the father's car which to A. was a symbol of his father's power. Also, A.'s lack of ability to assume a mature masculine role was seen in his failure to use the car for the more mature purpose of dating, which had been his expressed desire, even though stealing the car allowed an abortive identification with his father. Obtaining the car, originally the means to an end, soon became an end in itself. Once it was attained, the original goal of achieving status as a man was lost sight of. The symbolic acquisition of masculinity—obtaining the car—soon roused anxiety about the actual achievement of masculine status. This became evident when A. provoked loss of the stolen car by being caught, as by policemen who were probable father surrogates, and by frequent accidents.*

A's ambivalence about exhibitionistic wishes was acted out in his fantasy of having a big and flashy car to show off in, and then removing all decorations. Similarly, the need to hide symbols of power was expressed in A.'s attitudes toward the special attachments which must be hidden. He must hide the sign of strength

*The accidents also may well have been an unconscious expression of hostile wishes against the father as well as self-destructive activity in response to guilt over this hostility.

from the punitive father surrogate and at the same time outwit him. This was consistent with A.'s feeling that he could not compete openly in the masculine world. Also, it is conceivable that removal of the attachments might represent impulses, which were turned against himself, to mutilate his father.

A., as has been said, would never steal his mother's car, his mother was always the one who would come to bail him out of jail and would drive him home. The trip home was really a pleasant excursion for mother and son. They would go to places of special interest and entertainment along the way back; and, on one occasion they even spent the night in separate rooms of a motel. Thus, when A. would steal his father's car and have his mother come for him, he was able to use the car to act out his Oedipal wishes to have his mother, harm his father by wrecking his car, have himself brought back to atone for his guilt by being punished by his father, and finally to retreat from the feared masculine status to a dependent state by having his mother come to get him and take him home. He could "steal" the car as a symbol of masculinity —which he desired and feared—because he knew he would not be allowed to keep the car.

Case 2

B., a man in his early 20's, sought psychotherapy because of ill-defined symptoms of a schizoid nature. This patient demonstrated a need to deny intense, hostile, competitive wishes directed at the father.

B. had a dilapidated automobile which his father wanted to replace with a new car. B. rejected this offer, suggesting that he should take his father's old car and his father take the new one. Although the father would not accept this suggestion and actually preferred his older car to a new one, the patient would not accept a new one from his father.

Comment. This patient's attitudes about cars express a desire to identify with a depreciated father figure, and an expression of hostility by keeping the father from having the car he wants. Refusal to take the better car serves to deny this man's intense competitive wishes toward his father, and, at the same time allows the expression of hostility by forcing his father to give up his own car. This hostility is permissible in the guise of altruistic interest.

Case 3

C., a boy of 16, sought psychotherapy after his father learned that he had been stealing cars for several months. There was no attempt to use the stolen cars for any personal gain. C. would occasionally offer rides to friends; often he would drive the cars a short distance and leave them. He would take cars in his home neighborhood, from family acquaintances and even in broad daylight. Three times when he was not discovered, he told his father of the thefts. He once broke into a neighbor's house and then returned home, without stealing anything, to tell his father of his action.

C.'s relationship to his parents was characterized by frequent fighting and a need to deny the existence of positive feelings for either parent. He tolerated his mother, a very attractive woman, somewhat seductive toward C., but looked upon her as incapable of loving him or of being loved by him. It was apparent that this attitude was a defense against Oedipal desires. On the other hand, C.'s need to fantasy a rift between his parents was expressed in his stories of imaginary intense parental conflict, alcoholic debauches, and fights, which were known to be entirely untrue.

C. alternately viewed his father, a person active in combating juvenile delinquency, as a complete failure, in spite of his considerable success in public life, or as an extremely dangerous adversary. He generally depreciated his father's successes; when the father obtained a new car as an annual retaining fee for a relatively small amount of work, C. felt that the father was a failure because the car was only in the middle-priced group, and the father did not have to work for it. For this reason, he treated the car as a depreciated object, and frequently would not drive it when permission was given, because everyone would know his father got it for nothing.

Toward the therapist, C. displayed the same provocativeness and ambivalence seen in relation to his father. He could not accept the value of therapy after it had served the immediate purpose of getting him out of trouble, yet he never failed to keep an appointment. Nothing that the therapist had to offer was of any value, and when C. was forced into the position of having to admit a need for help, he would respond with guilt and persistent attempts to provoke rejection. The therapist's car became the focal point of the relationship early in treatment. When the transfer-

ence was of a more positive nature, the therapist's car would be spoken of as the next best thing to a "hot-rod,"* a convertible. When the transference was marked by hostility, C. would remind the therapist that the car was *only* a Ford and two years old at that.

To C., obtaining the family car (along with permission to obtain a driver's license) seemed to be his only problem. Without a car, he felt that he could not be accepted by his peers, that he was not adequate as a "man," and could not attempt to obtain a date (which he insisted he desired).

After the father was seen a few times by the therapist, he was encouraged to let C. use the car. At this time, C. still did not date because he "could not be sure of the car on any specific night." When C. was told he could have the car regularly on Friday evenings, he could not take girls out because all his friends went "out on Saturday night." When an important affair occurred on a Friday night, C. ignored the subject completely.

C. would often provoke loss of permission to drive the family car, by baiting policemen, minor accidents, erratic driving where he could be seen by his father or his father's friends, and on one occasion by leaving the automobile radio running all night.

In addition to making the car the focal point of his conflict with the family, C. spent many hours daydreaming about cars. Although he spoke of using cars in terms of their power, speed, and other attributes imputing strength, he was almost exclusively concerned in the daydream with a girlfriend. This same theme is even more elaborately seen in C.'s associations in the initial interview.

C. had been telling how badly he felt after his parents discovered the car thefts:

"I told my parents I felt I was a criminal [like] when I was about seven—I took change from my mother's dresser and threw it out of the window. Maybe I wanted to be bad."

Therapist: "What do you mean, bad?"

Patient: "I consider the car incident bad, and so I am bad."

Therapist: "Only taking away is bad?"

Patient: "Yes: nothing else."

Therapist: "What else is bad?"

Patient: "Lying—raping is bad—destroying is bad."

*A "souped-up," extra powerful, ultra speedy car stripped of all adornments.

Therapist: "What do you think is the reason you threw the money out of the window?"

Patient: "... [evasive comment] My father was training [at college] at the time."

C. went on to say that he should be punished, and that his father should be more strict.

Again later, while discussing how C. provokes his mother to nag him, the therapist pointed out that C. gets attention from his mother's nagging. C. then said, "Maybe that's what I want —one of the reasons I took those *cars* was to get attention... [scratches scrotum] ... I have a habit of putting my hand in my pocket and scratching, and the more I scratch, the more it itches." Following this up, C. was asked about sexual activity, for which he emphatically denied any interest or desire.

Comment. As in the previous two cases, the car was used by C. as a symbol of masculine attainment, and C.'s ambivalence about the acceptance of the masculine role was seen in his ambivalence about accepting the use of the car. Since C.'s fantasy was that masculinity could only be obtained through a competitive relationship in which he destroyed, surpassed and stole from his father or father surrogates, it is not surprising that the auto was used to act out these feelings, too.

In the car-stealing, one finds the following results, condensed: By attaining the car, C. attained masculinity and respect. By stealing the car, he almost succeeded in destroying respect for his father and his standing in the community as a leader in work with juvenile delinquents, and C. further attacked the father by ruining or harming the father's car on a number of occasions. C. clearly recognized this after he had taken the autos and his father actually had felt, more or less realistically, that he was compelled to resign his position in working with juvenile delinquents.

By stealing cars near home, in broad daylight, and from family friends, C. exposed himself to punishment and apprehension. That this exposure was motivated by guilt can hardly be denied, especially when one hears C.'s comments about feelings that he was thoroughly bad after stealing the car. Since C. actually feared assuming a masculine role (perhaps because of fear of retaliatory injury for his own hostility), his apparent need to be caught probably also represented an attempt to avoid assumption of that role by forcing his environment to set limits. This is suggested by the

complaint in the initial interview that his father had never been consistently strict in punishing him. Actually the father was inconsistent; frequently he would not decide on limits for C.'s behavior and would permit C. to drive even before he had a driver's license. At the same time, his father would be very punitive toward C. in other matters, at one time actually threatening to hit the boy with his fists over a trival matter.

Stealing a car also came to symbolize to C. the acting-out of his wish to attain mother or her attention. This connection became spontaneously apparent in the first interview when C. associated the car-stealing with an early memory of stealing something belonging to his mother. That this is an Oedipal desire, as well as a need for dependent care, is suggested by C.'s comments that he might have wanted to be bad, and by his association to destroying and raping in the same context. The apparently irrelevant remarks that his father was away at college at the time of the early theft, and that the father should be more strict, are further supporting data. When C. then scratches his genitals and speaks of scrotal itching, he further suggests the sexual nature of his preoccupation with cars. Finally, the fact that C. uses adjectives which are usually reserved for women to describe a car lends further proof.

Case 4

A brief note will be presented here. D. was a seven-year-old psychotic boy, diagnosed primary infantile autism. He was intensely preoccupied in play with toy automobiles. In addition to "driving" the cars around, he would fashion, from plasticine, "light beams" for head, tail, and spot lights. He would often call them penes and would even remove one from the car and hold it to his own genital region, referring to it as his own penis.

Comment. See comment under Case 5.

Case 5

E. was a psychotic boy of eight. He showed no particular interest in cars, but one day was walking with the therapist toward the therapist's car and was begging for a ride. He said that he liked riding in the car because it reminded him of being carried by his mother, or of a baby in the mother's gravid uterus. His diagnosis was probable childhood schizophrenia, or severe primary behavior disorder.

Comment. In Cases 4 and 5, one can see even more graphically than in Case 3 how the car, parts of the car, or functions of the car can be used to symbolize both masculine and feminine functions. In Case 5, the female symbolization was used to represent marked dependent regression.

Case 6

F., an 18-year-old boy, sought treatment because of fears of going out with girls, inability to succeed in academic work or extracurricular activities in spite of more than average ability, and feelings of inadequacy. F.'s conflict was very much like that of C. (Case 3) in that he viewed success as coming only as the result of destroying the father or the father surrogate.

During the early weeks of therapy, F. spent most of each interview expressing great concern for his father's health, financial status, and the fact that his mother no longer cared for his father and that the parents were on the verge of divorce. F.'s conviction of the truth of these matters could not be shaken, although the therapist knew from previous contact with F.'s father that they were almost entirely false. F. spoke of his mother as "cute, gay, vivacious, and the life of the party." It was some time before F. could see that he had any but the most loving and altruistic feelings toward his father. Just at the time that F. was becoming aware of his hostility toward his father, the father's business affairs took a sudden turn for the worse; and his father spoke of selling one of the three family cars (one was the patient's jalopy). Immediately F. was sure that all his worries were justified and that the therapist's doubts about their validity were wrong. The old fears returned in full force, and F. even obtained a full-time job, in addition to going to college, to help his parents out financially. Now they would not have to sell the car, and F. could prove to himself and the therapist that his convictions were correct.

Very shortly after obtaining the job and lending his parents some money, F., who ordinarily was a cautious and careful driver, had three auto accidents in two weeks. The second and third were minor accidents in his own car; the first had completely demolished his father's car. (F. had been bringing the father's car home from the garage after he had paid for some repair work with his own money; F. often cared for his father's car though neglecting his

own.) It is interesting to note that F. failed to tell his therapist about the accident for two weeks—until the therapist commented that he seemed to be even more guilty than usual about his father. Almost immediately, and as if by revelation, F. was able to see the significance of the accident.

F. also used his car to express the same kind of hostility in the transference as that toward his father. When F.'s father was having his business problems, F. decided to pay for part of his treatment fees out of his own money. One token payment was received, and no further discussion of fees was heard for two weeks when F. told of purchasing a newer car to replace his first car, which had not yet been sold. When that car was sold, the patient was reluctant to discuss the financial transaction. No further payment of fees was offered when the patient sold his second car.

Comment. Although F. did not happen to discuss cars as a symbol of masculine power, it is rather likely that they were so used by him. The fact that he seldom used his father's car, a high-priced station wagon, and that he preferred his own jalopy, parallels F.'s need to avoid assuming a masculine role. He also used the car to support his excessive concern for his father—actually a defense against F.'s hostility to, and competitiveness with, him. Also, the car became the instrument whereby the hostility to the father was acted out by demolishing the father's car. F.'s need to punish himself after wrecking his father's car was carried out in token form by wrecking his own car. Finally, the patient's car was used to act out the transference hostility.

Case 7

G., a colleague, contributed observations on himself, and on some of his associates during military service, about attitudes toward automobiles. He recalled that during his own adolescence, he would drive at high speeds and have a genital erection.

Although G. did not make observations on the driving of his military associates, he did note some of their attitudes about cars. Married officers showed least interest in their cars and spent a minimum of time caring for them. Men in the bachelor officers' quarters, however, would spend much of their free time working on their cars, polishing, washing, or just tinkering, as by doing minor repair work. As heterosexual interests became established,

activities with the cars became much less frequent. G. himself was in the group of bachelor officers who spent much time with their cars. He did not give up these activities until marrying, at which time he said he "preferred to spend the time with my wife." His car, incidentally, was named after a popular literary character, who was known as a faithful wife.

Comment: A relationship is seen to exist between behavior with a car and the expression of sexual interest. Whether the bachelor activities served as a defense against sexuality, an outlet for sexual energy which could not be discharged by men because of their realistic situations, or both, cannot be said. The excessive tinkering with, and manipulation of, the cars, seen here and frequently observed among adolescents, tends to suggest masturbatory activity. This is supported by the fact that the men gave up tinkering when they established heterosexual interests.

Case 8

H., a 19-year-old patient, was describing during the course of his analysis the "most ideal" situation of which he could conceive. He either wanted to drive a car or remain in bed, thus indicating first a wish to retreat from a "masculine" activity to passivity, and at the same time, equating driving the car with a passive wish.

Discussion

It is often assumed that the automobile is a symbol of masculine attainment, at least to the adolescent. Many adolescent, and even adult, "hot-rod" enthusiasts value their cars for the fact that the engines have been "souped-up," and other changes have been made in an effort to increase power and speed.* Owners of conventional cars, both adolescent and adult, frequently speak proudly of the speed and power of their cars. Even extra exhaust-pipes (possibly phallic symbols) are added both to increase engine power, and, more important, to attract attention.

Except for one adolescent and the two children, the subjects all spent some time in preoccupation with the power and speed of their cars as compared to the cars of other males with whom they were in competition. Four used their automobiles among their primary means of satisfying needs for masculine supremacy

*It takes little stretch of the imagination to see in the term, "hot-rod," a definite phallic implication. Much automobile advertising is, of course, designed to appeal to the need for power, for masculine supremacy.

and power. The subjects who showed much conflict about the acceptance of masculinity did not achieve the security about their masculine status which they expected when they obtained cars. Often, the car merely served to increase anxiety and to increase the need to deny masculine strivings. Three subjects behaved with their cars in such a manner as to provoke removal of permission to drive, or loss of the ability to drive. Two, who most ardently desired powerful, exhibitionistic cars loaded with "flashy trimmings," stripped their cars, when they obtained them, of the very exhibitionistic adornments they had so much desired.* In other instances the car was used as an excuse to avoid the one masculine activity that its acquisition was designed to accomplish —the car took so much time and money that none was left for dating or heterosexual association. This result was seen in two of the subjects.

In addition to being a symbol of masculine success, the automobile or its function was also viewed by three subjects as a symbol of, or substitute for, feminine (sexual) goals. One subject who stole automobiles began to talk—when asked about his car stealing—about stealing from his mother when he was young, taking from his mother in his father's absence, and wishing that his father would prevent him from taking things from his mother. This boy, also, had a great need to believe that his parents could not love him, and that his parents had no love for each other. Another subject, in stealing his father's car, always arranged a situation so that he would get his mother's attention. He would have to have his mother come and get him in her car when he became stranded after being caught in his father's car. Another subject observed an inverse relationship between activity with cars and heterosexual activity in the military service.**

Automobiles were also used as symbols of mothering or dependency-seeking by three subjects. One was the adolescent who had always obtained his mother's attention when he ran off in his father's car and his mother would have to come after him and literally "baby" him on the way back home. Another was the

*This is not an uncommon practice of adolescent "hot-rod" enthusiasts. One even sees this disadornment carried to the extreme in which cars, having been stripped, are occasionally decorated with depreciated objects and depreciating slogans.

**Not only do the advertising writers play on masculinity striving (as previously noted), but they also appeal to this feminine symbolic significance in their emphasis on beauty, sleek lines, and so on.

adolescent who had, as his two prime goals in life, driving a car or spending all his time in bed. The third was one of the young children, a probably psychotic boy, who equated riding in the car with being carried by his mother or being carried in his mother's gravid uterus. All three emphasized the seeking of comfort in the car, and two of them definitely used the automobile as an actual means of attaining—or as a symbolic equation with the attainment of—a close dependent relationship with the mother.*

Gratification of numerous other impulses is often seen in activity with automobiles. For example, anal-smearing impulses are suggested by painting and decorating the car, waxing, and polishing, which all but the two child subjects and the one adult enjoyed and frequently engaged in. The nature of the manipulation of the car also suggested that this might be a masturbatory substitute. Interest in the use of loud exhaust noises through specially designed mufflers might also be considered as expressing some anal impulses as well as phallic exhibitionism.

Since all males experience some conflict with their fathers in the final working-out of the Oedipal situation, the conflicts seen in the neurotic subjects of this study can be looked upon as exaggerations and distortions of the normal. In the same manner, the ambivalence about the assumption of a masculine role—and all of the other needs for which the adolescent subjects used their automobiles as solutions—are in all probability similarly exaggerated distortions of normal adolescent problems in boys.

That this assumption is true is certainly suggested by the widespread and intense interest in cars by adolescent boys.

Although the automobile has become a nearly indispensable means of transportation in our society, interest in cars has not been restricted to the rational aspects of merely obtaining a more efficient, rapid, and safe means of transportation. This is true of both the adolescent and adult population. Although manufacturers of automobiles do strive to improve the practical qualities of their products, they spend considerably more attention, money, and advertising, on other aspects, which apparently seem to them to have more customer-appeal. It might be argued that these pressures from the advertising and manufacturing sources have shaped the behavior of the population toward automobiles.

*This too, is used by advertisers in their emphasis on comfort, though here there is perhaps a more realistic need to be met. See the preceding footnotes.

In part, this is probably true; but the leaders of these business concerns are well aware that they can influence the public only to a limited extent, independently of the public's desires. The "better mousetrap" philosophy prevails, and they know that they must offer what the population needs or wants to a large extent; hence, one sees increasing stress placed, not only on the low price of cars to meet an apparently important social need, but upon the personal satisfaction to be gained from owning a new automobile. The appeal is both to the man, who generally purchases the car, and to the woman, who influences his choice.

Since this paper is a study of the automobile's significance to males, especially adolescent males, only this restricted aspect of the subject is considered here. Many of the qualities of the automobile that appeal to the public may appeal to both sexes, although for different reasons. As a means of expressing needs for, and as a solution for, conflicts about masculine status, power, and prestige, the automobile is admirably suited, because it is a powerful machine under the direct control of the driver. It affords the adolescent as well as the adult male the ability to compete in terms of speed, getaway, and similar matters, with every other male on the road. Because of the social and economic development of our culture, most men have cars, and the universal presence of cars in male society thus lends itself readily to the purposes of the various possessors of those cars.

Since the male adolescent has a good deal of conflict about assuming a masculine role, and a great need to prove his masculinity to himself and to his contemporaries, the car has apparently assumed a proportionately large significance in his behavior and psychic life. This certainly is true of the subjects in this presentation. Since the car is not only a symbol of masculinity but since it is also usually the property of the father, who has first call on its use and who has always been the purchaser of the car and the one responsible for its maintenance, the automobile assumes significant proportions as a focus for the conflict between son and father.

Because the father, for both realistic and neurotic reasons, cannot always allow the adolescent to have the car, the automobile often assumes the proportions of a very prized possession of the father. Thus it can become a substitute for the mother in the Oedipal triangle. It is only a short step from this, to view the

automobile as a substitute for a female sexual object as was seen in a number of the subjects. Because the car lends itself well to beautifying techniques, this permits another form of exhibitionism, as well as satisfaction of reaction formations against anal-smearing impulses.

Because the automobile is a means of being passively carried and of avoiding the need to show one's physical prowess, it serves as a defense against masculinity as well as a sublimation for more passive wishes.

Summary

Eight male subjects (five adolescents, two children and one adult) who demonstrated an interest in automobiles, and all but one of whom were in psychotherapy longer than six months, were studied in an attempt to determine some of the factors that lead to the intense interest of the adolescent male population in automobiles and driving. It was found that the automobile is expressly suited to the expression of the common needs and problems of adolescent males, as well as to those of many adult males in our society. This was found to be true not only because of the intrinsic nature of the automobile, which lends itself to meeting such personal values, but also because of the social significance that the automobile has attained in our society.

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MULTIPLE PSYCHOTHERAPY*

The Efficient Use of Psychiatric Treatment and Training Time

BY GEORGE M. LOTT, M.D.

Introduction

This paper reports the values observed when two therapists jointly participate in psychotherapeutic interview situations.

For six years, investigations have been made at Pennsylvania State University to determine the most efficient way of using the psychiatrist's time in psychotherapy in a service treatment and training situation. Graduate students, during advanced work for the Ph. D. degree in clinical psychology, take part in the activities of the university's mental hygiene treatment clinic. Experience in training co-operative therapists by multiple psychotherapy has already been reported.[1] These students were previously well grounded in counseling technics.

When case problems became more acute or involved and did not lend themselves well to staff supervision by going over the student's verbatim notes after interviews, another step was taken. Although traditionally it had been thought that only one psychotherapist could properly conduct deep therapy,[2,3] the clinic's psychiatrist began experimentally in 1948 the conducting of joint sessions with the patient and assistant therapist and actively participating in the treatment. It was found that the student therapist thus gained first-hand training and experience in how to conduct more active therapy and when to call upon psychiatric medical assistance. A brief analysis of the material after each joint interview could clarify the dynamics involved and amplify the instructions. With careful selection of cases, both the therapist and the patient usually accommodated themselves rapidly enough to this team work, and both benefited. The student therapist continued to keep the interview case records. The psychiatrist attended when necessary. This saved the psychiatrist's time and allowed him to supervise and treat more cases.

Other schools have experimented successfully with the use of two therapists. When 14 major university training centers, of 19 recently canvassed, answered questions about psychiatric resi-

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dency training, 11 stated they used "three way interviews (resident-teacher-patient)".[4] This was to give a demonstration to the resident trainees of the senior staff's interviewing technics. No mention was made of such team instruction in a prolonged course of psychotherapy.

At the Sunnybrook D.V.A. (military) Hospital, Toronto, during brief intensive therapy, three physicians experimented with one therapist taking a directing, authoritarian status and a second therapist a nondirective supporting role.[5] In the few cases tried, therapeutic movement was enhanced by the anxiety pressure fostered by the probing of the authoritative therapist, while the support of the other helped the patient to stand this anxiety. It was suggested that the ward physician could be the active, authoritative person and that the nondirective role could be taken by a psychiatrist or psychologist, provided he was trained in the technique of nondirective psychotherapy.

The foregoing findings would seem to indicate that multiple psychotherapy methods are appropriate for instructing advanced medical students and residents in training. Of course there should be careful selection of these trainees, whose backgrounds should give adequate preparation for such a process. Measures which promise to shorten the time elements involved should be of special value.

Case Illustrations of Methods and Clinical Training Values

A few illustrations will help to clarify the methods used, the way the treatment relationships were utilized, and the interaction of the two therapists.

A college sophomore, who had a severe anxiety neurosis with compulsive symptoms, involving early Oedipal factors and castration and incestuous elements, was under the co-operative treatment of the psychiatrist and student clinician. The supervising psychiatrist usually took the lead in the jointly-conducted interview situations. In the course of a year and a half of such supervised joint treatment, this patient worked through the castration phases of his mother-image and his passive father's failure to support and help him.

Observations were made on the transference situation when two therapists are involved. It was found that the patient might identify either of the therapists repeatedly at different times as

the mother, the father or a sibling. When the student became confused by these different identifications, the psychiatrist could give leads as to proper interpretation. The patient's identifications could then be handled to enable him to live over past undigested experiences.

When this particular patient was a little boy, the mother had repeatedly threatened to leave him if he was not "good." In addition, she had managed him in such a way that he also felt castration threats. The father was an emotional individual, who "made the money and let my mother and I determine how to spend it. When I got in an argument with him and he couldn't find an answer, he would just shut up and walk away. I wanted my father to control my mother and then I could be a man." The patient came to see that he had replaced his father in many ways, and, in effect, had pushed him out of the picture in his conversations with his mother and their joint decisions. The potential retaliation of the father was never very much in evidence, but it was nevertheless in the background. The patient had been berating his father, but, on suggestive interpretation, began to realize that most of his hostility was originally directed toward his mother for what he understood to be her threats of desertion and her derogatory attitude toward his father.

It became apparent that each therapist was being identified at times with both the father and mother images.

In this situation the patient said, "You [the student therapist] remind me of my mother and also of my father." The student therapist had been more active and aggressive in the interview than had the psychiatrist. The patient continued, "The doctor sometimes is like my father. At times he is more like my father because he is older." The psychiatrist had also been more permissive.

In another interview, when the patient tended to identify the student therapist unconsciously as the mother and the psychiatrist as the father, it was necessary to make a double interpretation to quiet excessive anxiety and make it possible for the patient to bring out more fundamental material. This young man had recently been very "set" on building his own home and had much feeling about it. The psychiatrist took the lead and asked, "In the light of what you have learned about your feelings toward your mother and father, what do you believe the house represents

to you?" After some thought, the patient turned to the clinician and said, "My freedom and manhood?" He hesitated until the clinician gave an affirmative sign before remarking, "This is the first time I have really understood what that house meant." Resistance was evidently overcome by permission of the clinician (mother image) to be emancipated.

When the patient was further drawn out in like manner, he was able, in the concurrent group therapy sessions, to begin to consider others' feelings, instead of always dominating or attacking them intellectually. With more questions containing interpretive suggestions, he was able to realize that resentment toward the distorted mother image was a main driving force in these acts. Working out such situations with the therapist was followed by ability to lessen his aggressiveness. The group therapy sessions were conducted mainly by the psychologist.

The relations between the student therapist and psychiatrist had been very understanding and the student had been making rapid progress in improving his technics. The student became firmly convinced—because of the somatic factors brought out in many cases and the possible depth of simple surface problems —that he should see that the more involved problems had psychiatric attention. Under mutually co-operative conditions, the transference identifications of the patient appeared to be very similar for both of the joint therapists.

The interplay with two therapists can reveal emotional disturbances rapidly and help in their resolution.

A 21-year-old, very withdrawn girl, a sophomore, complained of four years of gloomy spells, fearfulness when alone, and breathlessness when a boy was attentive to her. She was attracted by young men, but also repelled by them. When small, she felt left out of a family broken by divorce, "so that I was brought up in a vacuum." However, she did have some security with a grandmother from the ages of two to six. Residuals of early severe emotional deprivation (infantile autism) were suspected. There was a history of two months hospitalization for a schizophrenic episode at the age of 17.

In supportive exploratory interviews, the presence of two therapists seemed to bring out some pertinent aspects of her problems quickly.[6] In the second interview, while describing her symptoms and irritability toward her mother, she showed resistance.

The junior therapist was warm, reassuring and active, while the other's major effort was to draw out her inner feelings. When the doctor, the senior therapist, said, "You must have good reason for yelling at your mother and others who made advisory suggestions in a nice way?" The patient promptly replied, "I don't want people to tell me anything. I want to tell myself. I should take suggestions,..." It became clear that warmth, active suggestions or reassurance were interpreted as authoritative pressure, against which she habitually rebelled by "clamming up" and retreating.

In the next interview, this young woman illustrated her fearfulness when alone and also her apprehensive breathlessness and confusion when boys pushed her for affection. She resented the senior therapist at first, but also verbalized her preference for him later. This was illustrated when she reacted to the younger therapist with descriptions of difficulties with boys. "I don't like the doctor. I suppose he is like my stepfather, I don't know. I would rather be alone with a boyfriend or somebody like I told you [the junior therapist]." At the end of this productive interview, she turned to the doctor, who had shown little activity, and said, "Now I like you better."

There followed a few interviews when the doctor had to be absent. Then she brought out more ambivalence to boys who approached her. There was also expressed much sibling rivalry, a feeling that the mother favored her younger sister. There was a deep feeling that no one could love her. Her stepfather, whom her mother married when the girl was eight, was described as "indifferent." "If he'd make a suggestion, I'd drop dead."

With some misgiving, the senior therapist joined an interview 10 minutes after it started. The girl had just said, "I don't think my old man likes me. He criticizes me. He can't understand the way I talk to my sister. He upsets me and criticizes me. It drives me nuts to have someone tell me this or that is wrong, etc.... He is always looking for trouble and spends the whole day criticizing me. I like him, but he rants and raves about the stupid government etc.... I'd tell him off, but he might stop sending me to college."

It was at this point that the doctor entered the room and sat down quietly. The girl was aghast and turned to the junior therapist saying, "I won't say another thing until he gets out of here.

Why does he have to be here? I don't like him." The junior therapist asked, "Why do you suppose you feel that way?" The answer was startling, "It is like everybody is listening. He acts like he might be needed or wanted." When asked, "Are you afraid he will tell you what to do?" the patient replied, "I feel the same way to my old man. He makes me mad." The junior therapist asked, "You want to tell the Doctor off too?" The answer was, "I can't stand him. It upsets me for my father to be around [tears]. I feel I am using him for his money. He wants his family to have feeling for each other, etc. . . . [more resentment]—I hate him except that he is so nice. I can't express myself around him. He thinks he is always right."

The junior therapist said, "You perhaps feel that way about the doctor too?" She answered, "Usually my father is right."

The doctor then smiled and asked the girl for some examples. "We argue about football teams. If I disagree, he gets furious. In the end I agree to shut him up." The doctor asked, "Are there other reasons you don't stand up to him?" "I don't know." The doctor and the junior therapist simultaneously asked, "How do you feel when you don't argue with your father?" The reply was, "He built the house—he likes people to bow around." The senior therapist then remarked, "In a way you like him and in a way you don't?" The reply was prompt, "He is my father. I am not supposed to argue with him." The junior therapist said, "Perhaps you feel this way in other situations?" She answered, "I feel that way with people... If I don't get mad, it is because I am afraid."

The doctor suggested, "It is better to be mad than to keep it in and feel bad?" The answer was, "I resent my roommate too. I can act real nice if I want to, but I am afraid to. I feel guilty, as if I am being something I am not." The physician asked, "How do you feel here?" "I am not being anything here, nice or mean. I don't know what my natural self is around people."

The senior therapist asked, "Where do you feel relaxed?" Turning to the junior therapist, she said, "When I am with a fellow I like, I don't act at all."

It appeared evident that the patient had begun to work out of the antagonistic relationship to her father, and had begun to have less fear about transferring some of her affections to boys. There seemed to be more meaning to this transition, when this

young woman had both a father figure and a young man present in the treatment relationship. In some subsequent interviews, the two-therapist theme assumed the center of the stage. There came a surprised beginning sense that she might be likable to another person (the opposite of the core of her earlier autistic feelings). Thus this young woman's handicaps gradually faded, apparently the more rapidly because of having both an older and a younger therapist.

In another treatment process with an 18-year-old freshman girl, who had asked help in overcoming longstanding stealing and cheating, the junior therapist was resented. Evidently he aroused feelings associated with her rivals, her brother and mother. The senior therapist was associated with her desired father.

After a drawing-out process, she could be helped rapidly to see that the junior therapist had brown eyes like those of a close girlfriend, whom this patient had resented for having other friends when both the girls were 12 years old. "Then I felt left out." At this time, the girl's resented brother was one year old. Her father had explained the pregnancy when the mother had evaded questions before this child was born. It also appeared that the girl resented having a younger man (rival, brother, sibling) associated with a father figure, the senior therapist. However, this was overlooked, and the resistance to the junior therapist continued.

In a subsequent interview (after revealing her longstanding ability to get her own way by making scenes and the thrill of getting away with things like stealing and satisfying her residual, pressing, juvenile wants), the junior therapist was also revealed as representing a lenient, but inquisitive, old-fashioned, prodding grandmother.

The patient said of her grandmother, "We both get overheated. She will prod me until I tell her a full report. I had rather give freely of information, than be pumped. If I am in a bad mood, it will make me angry."

The junior therapist expressed the possibility that his questions might arouse her the same way that the grandmother's prodding did. She answered, "With my grandmother, I don't resent it so much. I get angry, but not at the right time. Grandmother wants a full report after a date and we are liable to have an argument."

The patient wanted to know what this had to do with her treat-

ment. The junior therapist explained, that in the treatment interviews patients often react to the therapists much as they did to some significant situation in their past lives. Then the patient complained, "It would be easier to accept you [the junior therapist], if the doctor gave more reasons." However, she quickly agreed that giving more reasons, would be exactly like prodding her to do something she didn't want to do. There followed a ventilation of her resentment at her mother's prodding at home when the patient had been cheating and stealing. Of course the mother only sensed unreasonableness and was ignorant of the serious misbehavior.

This student wrote a story called, "Mother Knows Best." She said: "In this story the mother dominates her daughter and insists on making the daughter have a great success while fulfilling the mother's own ambitions. I remember when I was in school, all the other children but me thought this was wrong of the mother. I felt this was the only way the mother could see of doing things. The daughter dies tragically, but the mother has a very successful funeral for her daughter and many celebrities attended. I think that the mother was not cruel, it was the only way she knew of doing things." After this ventilation of anger at family members this girl's ambivalence, feelings of duty and guilt, toward her own mother seemed somewhat relieved.

With two therapists, the transference identifications can have more range and ease of abreaction. This girl's identification of the grandmother shifted to the doctor, and the junior therapist was enveloped in the identity of suitor figures. This enabled the block in the problem of physical affection to be discussed promptly.

In the intervening interviews, she became more conscious of the risks her stealing and cheating involved, but felt the pressure of her parents for good marks. The mother would always lie for her, but the grandmother would not. The girl regarded herself as a "fallen angel." There then developed a resistance to talking in the hearing of the junior therapist about something which concerned recent relationships with a boy. It became evident that the doctor was acting as a grandmother person. She said, "I could confide in the doctor as a friend but not as a doctor." She also admitted that she always finally got her way with the grandmother. With this clearly in her mind, the grandmother in the person of the senior therapist consented to one special private interview.

It was then that her longstanding impression that "no boy ever liked me" came out. In the ninth grade she had petted with a boy and "felt awfully guilty for a whole year." "I can never get away from the strict morals in my family, and we did not discuss sex. I could not pet with a clear conscience." The senior therapist helped her to see that her feeling that no boy liked her and that she could not fall in love was adequately explained by this information. The normality of physical love was brought out, together with the realization that the objections involved only a matter of timing of such experiences.

Then it was possible for this 18-year-old student to reveal that she had been hard pressed for several weeks by a wolfish young man to become his mistress. She had engaged in heavy petting with soul-stirring, arousing feelings, but fortunately with less guilt than she had felt when in the ninth grade. Her resistance had finally led the boy to begin to retire.

The doctor asked if she could talk this over with the real grandmother now, but she said she felt her grandmother would not really understand.

In the resumed interviews she expressed more and more disapproval of her former habitual duplicity.

About the fifth interview after this, some of the early basis for her earlier confusions became manifest. The presence of two therapists seemed to aid in working this out. The girl was insistent on discussing something alone with the doctor again. It was made certain that she was not merely insisting on having her own way. "I never tell anyone my own age [like the junior therapist]. They are not understanding... With my family, they believe in a certain way, you could not make them understand. Neither of my parents understand each other... I'm ashamed to tell mother things."

The junior therapist asked, "First, I was the girlfriend, then the grandmother and mother, and now I'm also a girlfriend again?" The patient finally smiled and could reveal her problem to both therapists. "I'm going home this afternoon." She explained that she did not like to play with her longstanding boyfriend because she felt dishonest. "I do not like him... But I do enjoy his company. I'd like him better if I did not see him much; he is just a friend. We do not get involved morally, sexually, physi-

cally. He likes me very much but I have been playing with his feelings all along.

The senior therapist queried, "He is not like that wolf here then?" "No." "Do you trust yourself?" She answered, "How can you tell anyone you don't like him? I can't go on without him as long as there is no one to take his place."

The senior therapist, as the father figure, asked, "What is your father's reaction?" The reply was, "He thinks I'm unfair and... should not get... I should not lower myself. You see the boy can give me money and a rich home. Father says, 'Be fair.'"

The junior therapist asked, "And your mother?" "She says, 'Hang on to him as long as possible'... I might not get another. I almost wrote my father about it..."

The senior therapist voiced a question concerning what the boy thought. "He thinks we'll be married in about four years. How can other girls keep going on without committing themselves? How would they do it and still be friends?" After a period of silence she said, "*If I tell him, I guess we would still be friends.*" "It is absurd that we should be sure we would get married. What may happen in four years? I enjoy dating other boys."

"What would he think (feel)?" "It would hurt, but it would not be frank (honest) not to say it. This made me think the same about the boy, the wolf here. He had a girl at home and said it was just an affair with me." The senior therapist then asked, "Then you think in one way the wolf here was an honest one?" The reply was, "Yes, it is the reverse of the situation at home with the other boy and I realize it is. I never had a boyfriend sweetheart that I liked and he liked me. It never worked out. I fear I'll never find anybody. Mother says, 'keep him even if you don't love him'... She hopes I can love him and have money. But father doesn't think it is right."

The senior therapist said, "What about your grandmother?" (This question should have been asked by the junior therapist who had represented the grandmother, but it worked anyway.) The girl said, "She is rather like mother, but she is also concerned that I would hurt him or people. Grandmother would not accept it as part of a game and take it lightly." The senior therapist wondered if it was now really important what anybody thought, aside from what the girl herself concluded, so that she could have peace of mind and be satisfied. He then quoted her former re-

marks, "If I tell him [the longstanding suitor at home], I guess we would still be friends." The therapist simply remarked, "Yes, and you would be at ease with yourself?" "Yes [grins]." Then she suddenly said to the junior therapist, "I don't see why it made any difference whether you were here or not." Then she grinned again.

The senior therapist remarked about her uncertainty of finding someone she liked who would love her. He said, "It may be that when you like yourself—and it bothers you when you feel you are not honest—you may get so you can accept others who love you." Silence followed with a half-grin from the girl. The junior therapist asked, "Then you can feel carefree and trustful?" The young woman smiled, nodded and departed.

The junior therapist exclaimed, "We are getting an honest thief!"

Certainly this example illustrates how multiple psychotherapy can help a person bring out fundamental feelings and become aware of how one may have been led astray. This girl's resistance to facing parental figures with diverse opinions was worked through in the transference situation. This gave an opportunity for the junior therapist to represent girlfriends, the mother, the grandmother, and boyfriends, while the senior therapist was a permissive father.

Another important factor illustrated was the wisdom of following non-interpretive (non-directive) technics *until* the problems had been worked out sufficiently so that guilt reactions were minimized and the material was clear—and was either frankly verbalized or ready to break through to consciousness. The psychotherapist in training quickly became convinced that premature interpretations are a danger in that they only stir up deeply buried material without releasing it.

Two therapists were found to be helpful in managing an episode of acute disturbance, during the prolonged treatment of a student suffering from obsessional anxiety with schizoid trends. He would have periods when very confused, highly charged, early guilt-tinged traumatic experiences would emerge into consciousness. Memories and olefactory sensations would well up and "almost tear him apart." He had had a rather seductive immature stepmother. He had had sexual experiences at the age of seven with a teen-aged aunt, and there were oral aberrations at 14 years with an

adult woman neighbor. The memories were confused, and at times distorted and displaced, so that he would require frequent interviews, especially while hospitalized in the college infirmary. The fact that he had the two joint therapists seemed to aid the patient, because there were now two persons upon whom he could rely. When one could not be present during the episodes, the other could be reached. However, the liaison between the therapists had to be constant so that the conduct of the case and the remarks made by them could remain consistent. The patient tended to identify both as supportive, accepting parental figures, his own father having been deficient in this respect. However, at times, he also used the junior therapist in place of an older brother who had not been too closely identified with his problems. His ego was thus strengthened so that he developed more tolerance to tensions and to the diminishing echoes of early chronic frustrations.

The training values were remarkable. The junior therapist remarked, "Now I have a real belief in the Oedipal situation and its manifestations—not just an intellectual acceptance."

Joint therapy can react adversely if the two therapists, even temporarily, do not have similar objectives.

One 21-year-old patient suffered from severe and ominous symptoms, such as confused, unreal periods, vivid imaginings of people being hurt, fears that he would be attacked, and stomach complaints. He tended to work himself into a fatigue cycle. Only occasionally, could he express frank dislike of an anxious, "hypochondriacal mother" and a morbid "disagreeable father," both of whom had tried to protect this son with unnatural prudish attitudes. Finally both therapists believed him to require deep analytical therapy, time for which was not locally available. When the treatment program had gotten under control, he had been given supportive therapy while completing a strenuous project.

However, the first contact occurred while the supervising therapist was on vacation. A new trainee-therapist, who had just come on the service, discounted the signs for caution in the case record, because of seeming progress; and he attempted too active therapy.

When the joint therapy sessions began later, the patient was extremely productive with disturbing partial insights and tensions. The supervisor was attempting to reverse the trend to deep therapy by soothing acceptance, while the trainee would tend to

call the patient's attention to statements that had been automatically made and to ask questions which were too pointed. The patient produced a disturbing dream in which a man smiled at him and he became terrified. He also had passing thoughts that he might shoot someone. He complained that he could not sympathize with a sick wife when feelings about his hypochondriacal mother were active; in fact he was irritated by any illness. These happenings gave the trainee a constructive educational scare, especially when the patient reported that at bedtime he heard voices, one of which was now the trainee's. He said, "Since adolescence I have looked forward to the voices. When they occur, I know I am going to sleep."

Thus for a short period there was also some confusion in the patient, during which he produced graver symptoms, until the therapists became co-ordinated and returned to a more passive, supportive treatment with less frequent interviews.

Haigh and Kell,[8] working in the University of Chicago Counseling Center, report that in treatment by two therapists the shared responsibility and the opportunity for learning by direct observation facilitate confidence and competence. However, they warn that factors of dominance, competitiveness, submission, and hostility between the therapists must be faced and kept from nullifying both therapy and training. Buck[8] and Dreikerd[9] also emphasize these observations.

Lundin and Aranov,[10] working with schizophrenics at the Chicago State Hospital in group therapy with two therapists, feel that "corrective parent figures are needed." They find that if patients sense a "lack of respect" between the therapists, ("the same disharmony," or "infantile competition" which marked their own early home lives), "the patients would have no recourse but to further strengthen the defenses which were erected in childhood." These investigators added, "For this reason people who work as co-therapists must be reasonably conscious of their feelings for one another." However, those authors also noted a safeguard: Whatever the blind spots of the individual therapist, the chances were slight "that they would occur in similar areas in both therapists and be overlooked."

In the writer's observations during multiple psychotherapy, the patient will, at times even in a single interview, utilize one or another of the therapists as mother or father—alternatively as a

sibling or as a friend from among his peers. Lundin and Aranov have noted a similar phenomena in group therapy. The parents are also usually symbolized when identifications are projected onto other members of the patient group, although there are also sibling identifications.

There is further significant material in the way the transference relationships were utilized. Lundin and Aranov's[10] outstanding observation here concerned "the simulated family setting which is created by the presence of two authority figures... The most direct evidence comes from unconscious verbal slips and from irrational behavior growing out of the relationships, which the patients have with their therapists... Our experiences to date indicate that two therapists need not be of opposite sexes. One therapist will be seen as more aggressive and masculine, the other as more protective and feminine; one will be reacted to with more or less fear and guilt; one will be closer to the ideal image of the patient... The dominant partner may in reality be either the mother or the father."

The Attitude of the Patients Toward Having Two Therapists

What attitude did the patients take toward having two therapists? In the group therapy sessions concurrent with the individual therapy, their comments were enlightening. Those in the beginning stages of treatment showed resistances and identifications. They conversed somewhat as follows:

First patient: "Do you believe it is good to see two people and get different ideas? You do not have to take one person's word for it."

Second patient: "The doctor with 25 years of experience should know what he is talking about. If you don't like their suggestions, you can raise questions about them."

Third patient: "I have found the combination of the doctor and psychologist, to which I have been subjected or honored with, has been very good."

Fourth patient: "Don't you think the two working together is better than one? You can get two peoples' ideas instead of one, and if you don't like one you can go on to another."

Third patient: "Sometimes they don't agree and it confuses you for a while. I take what they both say and throw it out." (Smiles, and everyone laughs.)

FOURTH PATIENT: "That's right, but you are the third one and the one to satisfy. You have to satisfy yourself and take what satisfies you. You have to take what the psychologist says."

THIRD PATIENT: "Take the two of them, boil them down and come to your own conclusion and disregard both of them. That is about what I do continually."

FIRST PATIENT: "No, not with your emotions."

THIRD PATIENT: "No, not emotionally it is purely intellectually that I disregard them."

In this conversation there were naïvetés and definite signs of resistance, but also an appreciation of the support conveyed by two persons and an appreciation of the flexibility of the treatment situation. There was also a healthy frankness, as these statements were made in the presence of both therapists.

A fifth patient, after saying he had been through two years of such treatment, contributed more comprehension to the group. He took the floor and said:

"The doctor suggests something this way or that way. Occasionally the doctor would get a little positive and say—well, he didn't say this, but say he said, 'You have a mother fixation.' I say no, I don't have it. I start to argue with him, but there is no argument. My psychologist, the other counselor, uses non-directive therapy, and, well, just didn't say anything. I get peeved after a while. I think, why doesn't he say something (but what I said)?

"Obviously what the doctor said did not fit the situation. But over the whole period, over the two years, the picture clarified, with the combination of the doctor and his more directive therapy and the psychologist and his non-directive treatment. [The junior therapists are required to have had training in Rogerian therapy before this mental hygiene clinic assignment.]

"My attitude toward them changed entirely and I began to see what he was driving at. He would speak one or two words, the truth of the matter. He hit the nail right on the head, but the problem was not with them, but with me. I was hitting at the nail, but kept missing it. Maybe I hit it a glancing blow and did not recognize it, but he was the one who saw things in their correct perspective. As it cleared up, my antagonism disappeared entirely.

"After a long time the whole thing fell into a pattern and became clear. It was a most important thing for people to meet someone to whom they are antagonistic, and yet get someone

who is not antagonistic. With the other therapist, it makes an excellent ground for comparison and also might be a leverage situation."

From the patients' point of view, it is probably usual for multiple psychotherapy to seem to differ greatly from group therapy. One young man—who suffered from speech hesitation hooked up with a fear of expressing resentment—said to the psychologist in the joint therapy interview: "I have found in the group therapy sessions that I can consider my relationship to you and the doctor on a more human basis. Before I have always felt that I had to watch myself in our individual interviews. You and the doctor are not so superior in the group therapy, you are more human."

The group rather quickly reached a general agreement in approval of having two therapists.

Conclusions

It may be concluded that there are potentially definite advantages in having two therapists involved in the treatment-training situation, provided there is careful selection of patients and of personnel. Adequate safeguards can accompany excellent teaching, provided there are good liaison and tolerance between the therapists. Under these same conditions, therapists are very helpful in relieving each other, especially in managing very disturbed episodes, if they present a consistent front to the patient.

The supervising therapist can have practically as direct control of the process as he does when he is the only therapist. More cases can be carried, with more efficient use of professional time, especially if the trainee keeps the case records.

Probably less errors are made because of the alertness fostered by there being two therapists. Fewer mistakes pass unrecognized, provided supervisors and trainees are well enough prepared for such advanced training methods as can be used in multiple psychotherapy. An apparent mistake can usually be handled constructively, if it is clearly enough and promptly enough recognized.

It appears that special problems of relationships reflected in the treatment situation can be handled constructively, and often more efficiently, effectively and rapidly, when there are two cooperative therapists than when there is only one. The interplay with the therapists can often reveal pertinent emotional distur-

bances quickly, and help in their resolution. The transference identifications can have more range and ease of abreaction. Patients may repeatedly identify either of the therapists as a mother, father, grandparent, sibling or friend. The multiple identifications can be handled with unusual rapidity, in such a way as to enable the patient to live over vivid, past, undigested experiences. Many times there is a simulated family setting created by the presence of two authority figures: One of the therapists is seen as "more aggressive and masculine" and the other as "more protective and feminine."

The training values are remarkable in giving a close, first-hand, supervised experience to the students. Direct demonstration of therapeutic steps, choices of action and their effects are impressive and convincing. This is far superior to theoretical discussion based on descriptions, usually fragmentary, given by the trainee after an individual interview. Thorough checks by means of recordings, in addition to case notes, can be used as in the usual post-interview, supervisory conference. However, when both therapists have first-hand knowledge (the senior therapist having been present at least the last half of the interview and having caught up by reviewing the trainee's notes), supervisory time is shortened, and more concrete suggestions can usually be formulated.

Students have become convinced, because of the somatic factors brought out in many cases and the possible depth of "simple surface problems," that involved cases should have medical-psychiatric attention.

It can be forcibly demonstrated that it is wise to remain noninterpretive until guilt reactions are minimized, and until the material is clear and either frankly verbalized or ready to break through to consciousness. Likewise, the trainees can rapidly become aware that premature interpretations are a danger, as they can only stir up deeply buried material without releasing it.

There is general agreement among the patients and staff that multiple therapy is especially helpful. There are indications that most patients are favorably inclined toward it, and improve with it. In the course of six years, only two patients were actually antagonistic to the idea of having two therapists. One was paranoid. One had a severe initial resistance to confidences with younger people, a problem which multiple therapy brought out

so clearly that it was possible to get fairly rapid adequate resolution.

There are, of course, some disadvantages even with the most careful conduct of the program. Joint treatment will react adversely if the two therapists are unknowingly influenced by dominance struggles, or competitiveness or cannot use the co-operative team approach.

Under appropriate safeguards and adequate supervision, further study should be made of multiple psychotherapy, which also provides a means for more rapid and thorough preparation of junior therapists in training.

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REFERENCES

1. Lott, George M.: Training of non-medical cooperative psychotherapists by multiple psychotherapy. Read at the 1951 annual meeting of the American Orthopsychiatric Association. Am. J. Psychother., 6:3, 440-448, July 1952.
2. Dreikurs, Rudolph: Multiple psychotherapy in private practice. Read at the annual meeting of the American Psychiatric Association, Montreal, May 27, 1949.
3. Haigh, Gerald, and Kell, Bill L.: Multiple therapy as a method of training and research in psychotherapy. J. Abnor. and Soc. Psychol., 45:4, 659-66, October 1950.
4. Ward, Clyde H.: Psychiatric training in university centers. Am. J. Psychiat., 111:2: 125, August 1954.
5. Book, J. Carson, et al: Role-divided three-cornered therapy—Preliminary report. Psychiatry, 17:277-282, August 1954.
6. Grotjahn, M.: Special problems in supervision of group psychotherapy. Group Psychother., B., 309-315, 1951.
7. ——: The social meaning of current methods in group psychotherapy. Group Psychother., 3:56-57, 1950.
8. Buck, Alice E., and Grygier, T.: A new attempt in psychotherapy with juvenile delinquents. Am. J. Psychother., 6:711-724, October 1952.
9. Dreikurs, Rudolph; Shulman, Bernard H., and Mosak, Harold: Patient-therapist relationship in multiple psychotherapy. I. Its advantages to the therapist. PSYCHIAT. QUART., 26:219-227, April 1952. II. Its advantages for the patient. PSYCHIAT. QUART., 26:590-596, October 1952.
10. Lundin, William H., and Aranov, Bernard M.: Use of co-therapists in group psychotherapy. J. Consult. Psychol., 16:1, 76-80, February 1952.

BIBLIOGRAPHY

Alexander, Franz: Teaching psychodynamics. Am. J. Orthopsychiat., 17:4, 605-608, October 1950.

Dyrud, Jarl E., and Rioch, Margaret J.: Multiple therapy in the treatment program of a mental hospital. Psychiatry, 16:21-26, February 1953.

Hayward, Malcolm L.; Peters, Joseph J., and Taylor, J. Edward: Some values of the use of multiple therapists in the treatment of the psychoses. PSYCHIAT. QUART., 26:244-249, April 1952.

Hill, Lewis B., and Worden, Frederick G.: Participant teaching of psychotherapy by senior physicians: a hospital program and clinical illustrations. PSYCHIAT. QUART., 26, 228-243, April 1952.

Nash, H. T., and Stone, R. R.: Collaboration of therapist and observer in guiding group psychotherapy. Group Psychother., 4:85-93, 1951.

Solomon, Adrian, et al.: An analysis of co-therapist interaction in group psychotherapy. Int. J. Group Psychother., B, 2:171-180, April 1953.

Szurek, S. A.: Remarks on training for psychotherapy. Am. J. Orthopsychiat., 19:36-51, January 1949.

Warkentin, John; Johnson, Nan O., and Whitaker, Carl A.: A comparison of individual and multiple psychotherapy. Psychiatry, 14:415-418, November 1951.

Whitaker, Carl A.: A philosophical basis for brief psychotherapy. PSYCHIAT. QUART., 23:425-443, July 1949.

MULTIPLE PSYCHOTHERAPY*

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The use of more than one therapist at one time in individual or group psychotherapy has been called by many names—multiple therapy,[1-6] co-therapy,[7-10] role-divided, three-cornered therapy,[11] three-cornered interview,[12] joint interview,[13] co-operative psychotherapy[14] and dual leadership.[15] In the literature, there is mention of the use of from two to as many as nine[5] and 10 therapists[6] with a single patient; and mention of the introduction of guests (that is, interns and residents) who participate in discussions with patients in group therapy.[16] Furthermore, there are wide discrepancies, not only in the terminology applied and the number of therapists used, but more significantly, in the therapeutic methods employed when more than one therapist is in attendance.

The present evaluative review is undertaken, therefore, in an attempt to clarify the promising work done in this area, and to relate meaningfully the various reports to date. It is hoped that by communicating this material to other workers in the field some further impetus may be given to the exploration of this potentially rich technique. For purposes of convenience, the term "multiple therapy" will be used throughout this article when reference is made to any joint psychotherapeutic approach.

Historical Roots

The beginnings of multiple therapy have two major sources: (a) as a discussion of the patient's problem in his presence, and (b) as a teaching method.[17]

Discussion in the Patient's Presence

The early work of Alfred Adler and his co-workers at the Vienna Child Guidance Clinics is often cited as the starting point of multiple therapy. In 1930, those workers noted that: "... the appearance of the child before a large gathering ... has a stimulating effect upon him ... [because he is] surrounded with people who take a great interest in his fate and difficulties, without looking down upon him and without forcing this help upon him."[18, p. 23] This is elaborated elsewhere[18, p. 158] as follows: "It is advisable to say something good about the child to his parents or educator

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when he is within hearing distance. . . . He acquiesces in the consciousness of being appreciated . . ." Although these references may have stirred some interest in later therapists, they seem to the present reviewers to be of peripheral importance rather than a direct causal contribution.

A more structured handling of this sort appeared in 1947 when Hadden[16] permitted a group of interns and residents to attend sessions of didactic group therapy with neurotic patients. After a time, the students were asked to participate in group discussions and eventually to alternate as group leaders. Presenting and later discussing the cases of the patients present was found to give those under discussion "vicarious catharsis."

In the preceding two publications it is evident that there was no planned interplay between the therapists and the patients. The primary consideration was that the patient be present, thereby benefiting by hearing his problems discussed or by feeling appreciated. One finds more recent refinements of this technique in the work of Moreno,[19, p. 385] who uses a "trained auxiliary ego" to play the part of the patient, or other important personages, in the patient's presence. Dreikurs and his co-workers[1, 20] have one therapist use the patient's "private logic" to argue with another therapist, who interprets and evaluates while the patient "listens in." In conclusions drawn from a similar situation, Hayward[5] feels that the very intensity of the therapists' arguments impresses on the psychotic patient their desire to help him.

Use as a Teaching Method

Hadden[16] found that the direct employment of students in therapy sessions gives them a more intimate understanding of psychotherapy, while at the same time permitting continual supervision. In 1949, Whitaker[10] reported that for six years he had used multiple therapy to teach the general practitioner to handle some of the lesser emotional problems of patients. His findings were that the physician who had participated in such a course was less pessimistic in consequence about psychiatric patients, and that his increased knowledge facilitated the patients' moving into more intensive psychotherapy. Whitaker, Warkentin and Johnson[21] further report the didactic efficiency of this method in developing the capacities of the therapist.

Haigh and Kell,[4] in a more recent article, stress the fact that

inexperienced students can learn only by participating, and that multiple therapy reveals hidden difficulties and failings more readily than postsession supervision. Research possibilities inherent in the procedure are also pointed out.

Lott,[14] trained nonmedical psychotherapists (clinical psychologists) by this means. These psychologists employed nondirective methods with patients suffering from mild personality disorders; but, when problems arose, the psychiatrist conducted joint sessions, using a more direct approach.

Hill and Worden[12] report on the participation of senior physicians in the therapeutic endeavors of the junior staff. On weekly rounds the senior psychiatrist demonstrated techniques to the resident while helping and supporting the patient. However, in the cases reported there was little indication of three-way interaction. The senior member most often resorted to individual sessions, with the patients being seen by the resident.

Grotjahn,[22] who at times supervised his students as a participant observer, experimented with a few psychotic patients, whose doctors he supervised, and found that joining doctor and patient approximately once a week was very stimulating to the treatment situation. When he supervises or is consulted by group therapists, he joins the group, with little previous introduction or preparation—to get first-hand evidence of what is going on. Initially, he only observes, but later he takes over the conduct of the group, thus demonstrating to the therapist his constructive criticisms. This experience is analyzed and worked through in later meetings between supervisor and therapist.[23]

To several of the foregoing authors,[10, 16, 21, 22] it soon became evident that although multiple therapy had been initiated as a teaching technique there were some unique therapeutic benefits to be derived by the patients from this approach.

Treatment-Centered Multiple Therapy

The present reviewers were able to isolate three major ways in which multiple therapy is used as a treatment technique, in contrast to its use in training or research. These are: (a) intervention multiple therapy, (b) alternating multiple therapy, and (c) full-term multiple therapy. Although all three methods are used when treating individual patients, the last method is most frequently used by group therapists.

Intervention Multiple Therapy

Intervention multiple therapy is multiple therapy used primarily to dissolve a therapeutic impasse. The consultant therapist enters an established therapeutic relationship and may leave before therapy is terminated.[12, 24] There are times, however, when treatment is terminated only after multiple therapy sessions are completed.[3, 25] Sometimes the second therapist may take over completely.[14]

Whitaker and his co-workers[24] describe the calling in of a consultant therapist when a therapeutic impasse is reached. In almost all cases, the patient and his original therapist band together to exclude the consultant and to deny the possiblity of therapeutic failure. When this happens the consultant withdraws, having achieved his purpose of breaking the impasse.

Hayward[5] also has utilized multiple therapists to intervene in case of an impasse, particularly one created by transference and countertransference difficulties. He describes a hebephrenic patient who, after five multiple therapy sessions with nine doctors, was free of overt psychosis and able to leave the hospital. Hayward feels that multiple therapy allays the fears a single therapist might have in a dangerous situation, and that the patient feels safety in numbers. Furthermore, it allows the patient to divide and direct toward different therapists intolerable mixtures of love and hate, and increases the speed of treatment.

Dyrud and Rioch,[3] working mainly with psychotics, also find multiple therapy an excellent method for clarifying difficult transference and countertransference problems. The change of intensity of interaction between patient and original therapist following the introduction of multiple therapy is an important criterion of therapeutic improvement. As a side effect, the working relationship among staff members is found to improve.

Alternating Multiple Therapy

In this technique, multiple therapy is a predetermined, more or less fixed, consultive arrangement, with the consultant coming in for only a specified number of sessions. Here too, it may happen that the second therapist takes over.

This method was introduced by Dreikurs,[1] and later further elaborated by Dreikurs, Shulman and Mosak.[2, 20] It involved the first use of the term "multiple therapy." The process may be de-

scribed as follows: The patient is first seen by the senior psychiatrist. In the second and third sessions, an associate attempts to determine the patient's "life style" which is then defined in the first joint interview (the fourth session). The conclusions of the joint session are then reviewed in the fifth session by the senior (active) therapist. From then on, following every two or three single interviews with the active therapist, there is a joint session in which the material brought up is reviewed. Although the active therapist may decide on the frequency of the joint interviews, they must occur at least once in five sessions. If a negative attitude toward the active therapist should develop, the second therapist may trade roles with him.

In contrast to other reports of multiple therapy, Dreikurs, et al. find that emotional attachment to the therapist is not necessary for progress. Perhaps their particular use of the consultant therapist may account for the lack of development of intensive transference relationships and their feeling that two therapists hinder the development of countertransferences. They do, however, mention the necessity of evaluating any transferences which do occur. As the main values of their method, they hold that it enhances interpretations, shortens the reorientation period and allows the patient to open up more readily without fear of abuse. The presence of two different therapists, each with his own personality and approach, allows the patient to modify his expectations about people and to see that one can be wrong without loss of stature. Thus introduction into group psychotherapy and ultimate termination of treatment are facilitated.

Full-Term Multiple Therapy

In Individual Therapy. In this method, multiple therapists operate in a fixed number throughout a treatment relationship.

Reeve,[18] using a social worker and a psychiatrist with a single patient in a joint interview, recognizes as one value of this technique the elimination of distortions of the patient's accounts. He also recognizes the requirements of complete acceptance by the staff because "our own anxieties and concerns were readily reflected in the responses of the patients."

Whitaker, Warkentin and Johnson[21] initially used multiple therapy as a teaching method to develop the capacity of the therapist. Two therapists jointly conducted the entire course of individual

therapy, while a separate psychiatrist assumed all administrative functions. These workers feel that "countertransference is the fundamental force in brief psychotherapy," but also stress the value to the therapists of sharing with each other their emotional experiences in the therapeutic interview. In another paper,[8] these same authors describe their work with 25 patients of all types, seen individually, in which a constant number of from two to 10 therapists participated in from five to 30 interviews. As in their previous paper, Whitaker and his co-workers show considerable interest in the method as an aid to the professional growth of the therapists. They note that the intensity of the patient-therapist relationship is proportionate to that between therapists, or at least is limited by the latter. In their discussion of the advantages to the patient of this method, they include such factors as greater support and help, greater pressure permitted, and the fact that positive and negative attitudes toward different therapists give more incentive to work through these feelings at one time.

Bock, Lewis and Tuck,[11] after working with five of nine ward cases in individual therapy, arrived at their "role-divided" method, which they then applied to their remaining four cases. They consider this method useful as a type of brief therapy.

In Group Therapy. For the most part, multiple therapists in group therapy operate in a more or less fixed number over an extended period. The second therapist may be a participant observer.[26]

In at least two instances, however, the length of treatment is comparatively short. Orange[27] used multiple therapy as a "modified" method of brief group psychotherapy with psychotics. Lundin and Aronov,[8] also working with psychotics, used two therapists for from 25 to 30 sessions with groups of 12 patients. They feel that reactions in the group reflect stability and instability in the home; and they find co-therapists better able than single therapists to evaluate the responses of the patients and of each other. In their groups, clarification of the patients' present attitudes was stressed. Two therapists offer a "broader dynamic area to which the group can react." Furthermore, they report, they could treat 12 patients rather than the usual six to eight treated by a single group therapist. They, too, underscore the need for good therapist-therapist relations so as not to reproduce traumatic family settings.

Demarest and Teicher[7] report group therapy with hospitalized

schizophrenic men, using one man and one woman therapist and holding two one-and-a-half-hour sessions weekly for one-and-a-half years. Stressing the use of working through transferences as a therapeutic tool, they point out the importance of the co-therapists' roles. They indicate the possible levels of transference to be patient-patient, patient-therapist, patient-group, therapist-group and therapist-therapist, and consider the direction, depth and intensity of these relationships. They further suggest that, because the therapist who is not crucially involved in an interplay at a given moment can be more objective, he can clarify what he observes.

In many instances a group's observer is drawn into the group interaction and treated much as a co-therapist. Joel and Shapiro[28] write of a co-therapist or "recorder" who summarized developments near the end of the group session, drawing much hostility which would have been directed toward the main therapist, and leaving the main therapist as a benevolent and nonthreatening authority figure. Powdermaker and Frank[29, pp. 9-14] also note that group therapy patients sometimes address comments to an observer instead of to the therapist, and suggest that an observer may be used as an object of acceptance or hostility originally felt toward the doctor. Illing[30] delineates three types of multiple therapists: the co-therapist, the observer, and the visitor. He feels that—while the categories of co-therapist and observer have been fairly well defined and show some direction—the role of visitor is more nebulous. He points out the impact of the visitor on the group members and therapist, and concludes that although the visitor's role differs from that of co-therapist or observer, all three have certain common generic transference elements.

Bach[31, pp. 60-64] suggests that a therapist who is carrying a group member in individual treatment sit in on the group sessions to avoid the negative effects of "parallel treatment" by keeping the focus group-centered.

Naturally there may be a number of variations in the use of multiple therapists. For instance, Linden's senile women patients[16] were seen three times a week over a two-year period by combined and alternating therapists. That is, the male doctor occasionally would leave the group and allow the nurse to take over, and vice versa. The occasional alternation of therapists

tended to stimulate response and activity, keeping attention focused on the procedure.

Different Approaches to the Role of Therapist

Many of the papers reporting on multiple therapy place particular stress on the importance of the roles played by, or imposed upon, the therapists.

Roles in Individual Therapy

Bock[11] and his associates tried complete equality of therapists at first, but then felt that the resistances that developed stemmed from too much pressure from two authority figures. As a consequence one therapist became directive, controlling the discussion and increasing pressure. The second therapist became nondirective, giving support and reflecting feelings—thus enabling the patient to feel more secure and more at ease under pressure. This is an example of an attempt by therapists to impose their roles on the patients.

Reeve,[13] on the other hand, finds that patients impose roles upon their therapists. His seating arrangement approximated an equilateral triangle and allowed the patient to identify with one therapist and turn his back to show rejection by, or resentment toward, the other therapist. However, Reeve also felt that a man psychiatrist and a woman social worker more easily set up a parental situation.

Warkentin, Johnson and Whitaker[6] are in agreement with Reeve that it is the patients who define the roles of the therapists. Their patients, they say, sensed differences in the personalities of the therapists and tried to play one off against the other. One therapist was defined as harsh and punitive, another as soft and giving.

Roles In Group Therapy

Demarest and Teicher[7] feel that, in group therapy as well, cotherapists of different sexes offer a more complete and realistic setting in which to learn new life-patterns. According to those authors, a man and woman therapist in group therapy allow the patient to relate to the figure of one sex alone, to one in the presence of the other and to both together. Such a setting facilitates the acting out of a family group situation, sibling rivalry, mother-son and father-son relations, and heterosexual problems. The therapists may consciously manipulate and reverse their roles and

point out differences from real parental roles. Joel and Shapiro[28] agree that two therapists, particularly if they are of opposite sexes, more immediately revive the family situation.

Linden,[15] working with a group of 51 institutionalized senile female patients, felt the need to re-evaluate multiple group therapy as it relates to the chronologically aged. Male and female co-therapists provoked "hidden transferences into bolder expression," and the woman nurse in particular aroused a spirit of competition which carried over into habits of dress, personal hygiene and feminine interest. The male and female therapists "may revive repressed ideals of comradeship in the disillusioned senile," and bring back a mixed social world. At a deeper level, the presence of the woman therapist in particular was felt to reconstitute a family pattern, by arousing Oedipal strivings and mother-dependent feelings, which then had to be carefully handled by facilitating identification and avoiding overprotection. Linden concludes that this type of group therapy adapts itself especially well to the treatment of these repressed, dependent and affectively-starved patients.

In a searching analysis, Lundin and Aronov[8] write that two authority figures help simulate a family setting especially well for schizophrenics, who, they consider, think symbolically. In group therapy, the group members may take on parental or sibling roles. In contrast to many other writers, these authors state that two therapists need not be of the opposite sexes to be given father or mother roles. Schizophrenics in particular respond to subtle psychological differences in the therapists. The more aggressive therapist is equated with the masculine role, the more protective with the feminine. The implication here is that the personality of the therapist not only determines the role he plays, but also the role given him by the patients, who will have a primary reaction to one of the two therapists. Once this reaction is fixed, the second therapist assumes in the patient's mind the secondary qualities associated with the less dominant parent.

Slavson[32, pp. 111-112] writes that, from the theoretical point of view, multiple therapists for non-psychotic patients are undesirable, since transferences are diluted or confused. He goes on to remark that adolescent and adult patients who are otherwise suited for group treatment do not require the duplication of a setting similar to early childhood, and the presence of a male and female thera-

pist may encourage abreaction rather than insight. He reports that—in an activity group of children about nine years old—the use of a man and woman therapist confused the children as to the roles of the two adults.

Although Illing[30] disagrees with Slavson's contention that co-therapists necessarily dilute transference; Solomon, Loeffler and Frank[9] not only do not contest his statement, but rather feel that "diluted transference" may be a definite advantage in working with groups of psychotics, as they did. By the same token, they feel that "diluted counter-transference" in multiple therapy is another advantage of this method. These authors discuss rather extensively the problems of interpersonal relations between co-therapists. They point out the possible subtle manifestations of therapist-therapist conflict, as when the results of this conflict are displaced in the behavior and feeling of the therapist toward the patients. One suggestion they make is the construction of a directive-nondirective, active-passive rating scale. "The co-therapist method will produce optimal results when the personalities and orientation of the co-therapist are flexible enough to permit considerable variance along the active-passive, directive-nondirective continuae." They further suggest periodic discussions between co-therapists, preferably in the presence of a third person as moderator.

In a later paper, Loeffler and Weinstein[25] point out and summarize many of the advantages and special problems for patients, therapists and students of multiple group therapy. They feel that, as compared with individual therapy, the co-therapist method improves the possibility of the patient's attainment of catharsis, reality testing and insight.

General Summary

Advantages and Disadvantages

It is significant that Loeffler and Weinstein[25] mention "special problems" rather than "disadvantages." With the exception of Slavson,[32] none of the papers reviewed really criticize the multiple-therapist method. Rather, there are warnings about possible pitfalls and mistakes, mainly revolving around the feelings of the therapists toward each other. Thus, one therapist may resent the intrusion of another, or may compete unconsciously or feel threatened—with these difficulties subtly affecting the therapeutic

process. This potential for disruption, however, is also mentioned as having equal possibilities for being turned, by postsession discussion, to the advantage of the therapists in terms of overcoming these difficulties and achieving professional and personal growth.

Almost all authors agree that multiple therapy is an excellent teaching method, since it lessens the initial threat for the student and gives him the advantage of participant-learning with continuing supervision, while at the same time offering some protection to the patient. There is some mention of its value as a research technique, but the present authors could not find anywhere any specific discussion of how the use of multiple therapists makes the material more amenable for research; and, indeed, there is only one indication of how one would use multiple therapy as a research tool at all. Haigh and Kell, writing on this method as a means of training and research, make use of recordings, and assert that "... in multiple therapy, the variable of client personality is held constant—both therapists are responding to the same client."[4, p. 664] In other words, they maintain that here is a situation in which the patient is a constant, and in which the reaction of two different therapists to this constant can be explored. They suggest that this is a means by which to test such differing techniques as deep interpretation and reflection of feelings. However, the present reviewers fail to see how it would be possible to separate just what factors the patient is reacting to, since the end product is a result of the interaction of the techniques and personalities of both therapists. Furthermore, both therapists are not reacting to the "same" patient, since each therapist sees him differently.

The advantages of this multiple-therapist method in individual therapy range from protracted assault on the delusional system of a single psychotic patient to intervention in case of an impasse, and subsequent clarification of transference and counter-transference problems. There is little doubt that one of the major advantages of this method in both group and individual therapy is the prevention of overinvolvement and the heightened objectivity and clarification given by a second therapist who is not, at the moment, involved in an interchange with a patient. The greater transference possibilities of two authority figures, sometimes of the opposite sex, is a frequently mentioned advantage,

along with the important fact that, since all therapists have certain blind spots, two therapists lessen the area of these blind spots considerably, and offer concomitantly a greater potential for awareness of the patients' particular personality problems.[24]

Some Comparisons of this Method with Individuals and with Groups

There are some differences noted immediately when multiple therapy is used with individuals and when it is used with groups. For one thing, when working with individual patients, there may be many more than two therapists; there may be as many as 10. In the group situations described, however, there are usually only two therapists, with perhaps a third as an observer. Furthermore, from the descriptions given, it appears that individual patients treated by multiple therapists are often much more acutely disturbed and out of contact than are those treated in groups. This is particularly notable in the case described by Hayward and his associates.[5] It has recently been contended that psychotics form extremely intense transference relationships. If so, this fact might make multiple therapy an ideal medium for these patients and their therapists in many cases, since the transference and counter-transference relationships may be either "diluted,"[32] or better clarified in the multiple-therapist method.[9] The possibility of directing such ambivalent feelings as love and hate toward different therapists may also account for some of the reported successes of this method with psychotics.

Other factors may also operate to the advantage of groups of psychotic patients, and Orange[27] mentions multiple therapy as one of the possible modifications employed when treating psychotic patients in brief group therapy. It is suggested elsewhere that the easy symbolization by psychotics in re-creating two authority figures into a family configuration is a relevant factor in their successful treatment.[8] However, the writers should mention here that, in their own experiences with groups of nonpsychotic sex offenders, two male therapists are often perceived and reacted to as mother and father figures; and these transferences are in no way "diluted," as maintained by Slavson.[32, pp. 111-112]

In therapy of an individual, the patient may find support in one of the therapists while being directly challenged by another, although one of the pitfalls mentioned by various writers is the

danger of overwhelming and frightening the patient. For the therapist, too, there is the reassurance of having another therapist at hand while treating individual psychotics. In the group situation, on the other hand, the possibility of overwhelming patients is no longer of such danger, but the benefits of mutual support are perhaps much greater for the therapists. It seems probable that the addition of one more therapist to a group situation does not have the same impact as the addition of one more therapist in individual treatment, although it certainly must have meaning which is of equal importance to the patients. So very much is happening in a group at any single time that the benefits to the therapists of heightened observation and mutual support that are given by a second therapist must far outweigh the increased complexity provoked by his presence.

Problems and Implications of Multiple Therapy

One of the difficulties which plagues researchers investigating psychotherapy is the fact that the investigator affects what is investigated, an occurrence not unique to social science. This effect is especially marked when an observer or second therapist enters the therapeutic situation.[28-30] The only way to avoid this kind of situation would be to use a recorder or a one-way screen. However, a recorder misses the subtle nuances of therapy sessions, and although a one-way screen could conceivably eliminate many of these difficulties, such a set-up is frequently not available.

Despite difficulties, it is felt that the opportunity for learning much more about transference and counter-transference phenomena is inherent in the method of multiple therapy. At the moment, however, the subjective and qualitive elements must remain the primary subjects of investigation.

The present authors' experience in full-term multiple therapy may offer further understanding of the nature of the roles of the therapists. Although both therapists here are men, patients readily become involved in transference relationships, responding to either therapist with feelings originally directed toward parents and other important figures, regardless of the sex of the original object. Thus the family setting is easily reconstituted, though with each of the two therapists appearing at times to present the loved and hated aspects respectively of the same parent.

In the writers' opinion, these transference relationships are

neither founded simply on the congruence of the given therapist's personality with that of the parent in question, nor on an arbitrary projection of traits onto the therapist. Rather, the actions and attitudes of the therapist set the limits and direction for transference reactions. That is, the patient's projected feelings are found to be the implying of meaning or intent—the selection of which is in keeping with the general structure, or is an actual instance, of the therapist's behavior or of his objectively typical attitude. Although everybody viewed the two therapists as being different in general demeanor, and as having consistently recognizable trends, the patient's interpretation and response depends on inherent selective possibilities.

This distinction will perhaps be clearer in specific terms. To begin with, there is a sharp contrast between the "global" characters of the two therapists; that is, one would be described as "aggressive" and the other as "passive" by most people. The two groups in which they conduct multiple therapy also differ in important ways. One group is more analytical, intellectualized and verbal in its approach to problems, and its members are for the most part neurotic and schizoid individuals, with no prior institutionalization, no nonsexual offenses, and a superficial picture of social conformity. In contrast, the other group engages in much psychopathic acting out of problems within the group (to the extent of fist-fights and open homosexual banter during treatment sessions) with most members having either been incarcerated in the past, having also committed nonsexual offenses, and/or having been alcoholics.

Although the therapists do not intentionally take different roles, each group interprets their actions differently. Specifically, the "analytic" group has characterized the "aggressive" therapist as the "hatchetman" who "always makes you uncomfortable by probing and making interpretations," while the "passive" therapist is seen as "a nicer guy," better able to "help you and give you some support." The "acting-out" group, on the other hand, sees the former as "a guy who talks up and gets something done" and the latter as "a deadhead." Of course, an alternative interpretation might be that each of the two therapists themselves reacts differently to each group. However, continual examination of counter-transference problems and discussion of how the therapists see their own and each other's roles are conducted regularly

in postsession conferences. This self-corrective aspect of multiple therapy sharply minimizes such counter-transference patterns.

A clear instance of an individual patient's transference interpretations that were within the actual limits of the objective situation involved the introduction of an observer (a psychological intern). At first, there was no apparent reaction by the group. However, several sessions later, after much discussion of a patient's mother's lovers, this patient admitted seeing the observer as an "intruder." He became petulant and did not want to talk in the observer's presence unless the latter talked too, so that he could do battle with him. Thus the observer was intruding on the closed family circle of the group in a way that reawakened earlier resentments which would have been likely to be veiled for a longer time without this objective similarity of the entrance of a stranger invited by an important authority figure (first by the mother in the past, and later by the therapist). The other side of the coin for this patient was seen when the temporary absence of the therapist called forth feelings originally directed toward the patient's own errant father. The patient then described the group as being "like sitting down to a family dinner with the father away."

Thus, the effects of the introduction of the second therapist appear to make clear the need to eliminate the concept of transference as an arbitrary attachment to the therapist of old feelings toward the parent. Multiple therapy also allows the therapists to realize more clearly the role that similarity of cognitive structures of the old and new situations plays in making for selection of fitting feelings. A further implication is that, having come to understand his own personality patterns, the therapist may learn to use them therapeutically, rather than simply attempt to eliminate their effects.

Still to be answered, is the question of whether the time given by more than one therapist is justified either by a shortened period of treatment or more successful results.

It is only within the last seven years that this new technique has received more than passing reference in the literature; and so the current survey reflects necessarily varied and as yet unco-ordinated explorations. It is hoped that future papers will attempt more systematic investigations, from which may be gleaned the differing effects of various methods of multiple therapy with

individuals and groups—neurotics, psychotics, and other types of patient.

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REFERENCES

1. Dreikurs, R.: Techniques and dynamics of multiple psychotherapy. PSYCHIAT. QUART., 24:788-799, 1950.
2. Dreikurs, R.; Shulman, B. H., and Mosak, H.: Patient-therapist relationship in multiple psychotherapy: I. Its advantages for the therapist. PSYCHIAT. QUART., 26:219-227, 1952.
3. Dyrud, J. E., and Rioch, M. J.: Multiple therapy in the treatment program of a mental hospital. Psychiatry, 16:21-26, 1953.
4. Haigh, G., and Kell, B. L.: Multiple therapy as a method for training and research in psychotherapy. J. Abnor. and Soc. Psychol., 45:659-666, 1950.
5. Hayward, M. L.; Peters, J. J., and Taylor, J. E.: Some values of the use of multiple therapists in the treatment of psychosis. PSYCHIAT. QUART., 26: 244-249, 1952.
6. Warkentin, J.; Johnson, N. L., and Whitaker, C. A.: A comparison of individual and multiple psychotherapy. Psychiatry, 14:415-418, 1951.
7. Demarest, Elinor W., and Teicher, A.: Transference in group therapy. Psychiatry, 17:187-202, 1954.
8. Lundin, W. H., and Aronov, B. M.: The use of co-therapists in group psychotherapy. J. Consult. Psychol., 16:76-80, 1952.
9. Solomon, A.; Loeffler, F. J., and Frank, G. H.: An analysis of co-therapist interaction in group psychotherapy. Int. J. Group Psychother., 3:171-180, 1953.
10. Whitaker, C. A.: Teaching the practicing physician to do psychotherapy. So. Med. J., 42:899-903, 1949.
11. Bock, J. C.; Lewis, D. J., and Tuck, J.: Role-divided three-cornered therapy. Psychiatry, 17:277-282, 1954.
12. Hill, L. B., and Worden, F. G.: Participant teaching of psychotherapy by senior physicians. PSYCHIAT. QUART., 26:228-243, 1952.
13. Reeve, G. A.: A method of co-ordinated therapy. Am. J. Orthopsychiat., 9:743-747, 1939.
14. Lott, G. M.: The training of non-medical cooperative psychotherapists by multiple psychotherapy. Am. J. Psychother., 6:440-447, 1952.
15. Linden, M. E.: The significance of dual leadership in gerontologic group psychotherapy: studies in gerontologic human relations III. Int. J. Group Psychother., 4:262-273, 1954.
16. Hadden, S. B.: The utilization of a therapy group in teaching psychotherapy. Am. J. Psychiat., 103:644-648, 1947.
17. Whitaker, C. A., and Malone, T. P.: The Roots of Psychotherapy. Country Life Press. Garden City, N.Y. 1953.
18. Adler, A.: Guiding the Child. Greenberg. New York. 1930.
19. Moreno, J. L. (editor): Group Psychotherapy. A Symposium. Beacon House. New York. 1954.

20. Dreikurs, R.; Shulman, B. H., and Mosak, H.: Patient-therapist relationship in multiple psychotherapy: II. Its advantages for the patient. PSYCHIAT. QUART., 26:590-596, 1952.
21. Whitaker, C. A.; Warkentin, J., and Johnson, N. L.: A philosophical basis for brief psychotherapy. PSYCHIAT. QUART., 23:439-443, 1949.
22. Grotjahn, M.: Special problems in the supervision of group psychotherapy. Group Psychother., 3:309-315, 1951.
23. Grotjahn, M.: Problems and techniques of supervision. Psychiatry, 18:9-15, 1955.
24. Whitaker, C. A.; Warkentin, J., and Johnson, N. L.: The psychotherapeutic impasse. Am. J. Orthopsychiat., 20:641-647, 1950.
25. Loeffler, F. J., and Weinstein, H. M.: The co-therapist method: special problems and advantages. Group Psychother., 6:189-192, 1954.
26. Nash, H. T., and Stone, A. R.: Collaboration of therapist and observer in guiding group psychotherapy. Group Psychother., 4:85-93, 1951.
27. Orange, A. J.: A note on brief group psychotherapy with psychotic patients. Int. J. Group Psychother., 5:80-83, 1955.
28. Joel, W., and Shapiro, D.: Some principles and procedures for group psychotherapy. J. Psychol., 29:77-88, 1950.
29. Powdermaker, Florence, and Frank, J.: Group Psychotherapy. Harvard University Press. Cambridge, Mass. 1953.
30. Illing, H. A.: Transference role of the visitor in group psychotherapy. Int. J. Group Psychother., 5:204-212, 1955.
31. Bach, G. R.: Intensive Group Psychotherapy. Ronald Press. New York. 1954.
32. Slavson, S. R.: Analytic Group Psychotherapy. Columbia University Press. New York. 1950.

THE USE OF GROUP THERAPEUTIC METHODS IN WARD CONFERENCES WITH ATTENDANTS: AN AID TO PATIENTS' WARD ADJUSTMENTS*

BY SIDNEY B. JENKINS, M.D.

Introduction

Before general use of the new tranquilizing drugs in Wayne County General Hospital, ways and means were being sought to increase the effectiveness of the roles of attendants as secondary therapists.

Graeber, et al.,[1] with this in mind, attempted to use, under supervision, some aides as group therapy leaders. They found that, as the leader-aides came to know their patients better, they became more alert to symptoms of trouble and, frequently, by talking to a patient or by suggesting hydrotherapy to the physician, averted serious upsets.

Klapman[2] noted that when an attendant strayed into group psychotherapy sessions for the first time he got a "slant" on his patients that he had never considered before; and thus the potentialities of group psychotherapy for training purposes became manifest.

The writer attempted to use psychotherapeutic methods with attendants as subjects rather than patients. The purpose was to see, if by using the patient's adjustment as a pivot, one might then re-orient the discussion so that some of the attendants' own conflicts, problems, prejudices and misconceptions might be altered —at least in the areas where they interfered with constructive management of patients.

The presence of prejudices and misconceptions in the public hospital attendant population was well demonstrated by Middleton.[3] He believed, as the writer does, that education of employees can be used to better the treatment program. He found much uncertainty among employees about the patients in their care. Some did not know how to manage a patient in ordinary routine tasks. Their suggested methods ran the gamut from simply ignoring the patient to purposeful punishment.

From the writer's direct assault at the attendant level, it was hoped that improvement in the patients' ward adjustment might

*From Wayne County General Hospital, Eloise, Mich.

result secondarily from changed attitudes and new-found emotional insights. The program was carried out in a continued treatment building containing 240 chronic psychotic women patients.

Method

Eighteen conferences, one hour in length, were held approximately a week apart. Those in attendance were the doctor, nurse, attendants on the ward of the patient discussed, and visitors. The group of visitors varied in composition, but usually consisted of a supervisory nurse, attendants from other wards, and an attendant-supervisor.

Emphasis was placed on describing, understanding and improving the patient's ward adjustment. Only as much history was given as was necessary to clarify some aspects of the patient's ward behavior. Free expression of views was encouraged, although the subject consisted of the patient's adjustment in the main. The patients selected were in the categories listed in Table 1.

Table 1. Categories of Patients

Diagnoses	No. of patients
Schizophrenia, undifferentiated (one lobotomized)	9
Schizophrenia, paranoid	3
Schizophrenia, catatonic	3
Schizophrenia, hebephrenic	1
Manic-depressive psychosis	1
Involutional psychosis with paranoid ideation	1
Total	18

Factors contributing to poor ward adjustment are listed in Table 2.

Table 2. Factors Contributing to Poor Ward Adjustment

Factors	No. of Factors Involved
Agitation, verbal and physical	9
Impulsiveness, attacking attendants or patients	5
Refusal to eat	3
Refusal to or inability to take care of self or bed	4
Tantrums	2
Inciting patients with delusional ideation	3
Withdrawal	3
Failure to participate in therapeutic activity	11
Refusal to go to off-ward activity	9
Repeated attempts to escape	1

Results

A rating scale was devised to evaluate improvement. Each of the 18 patients received one of the four ratings listed in Table 3.

Table 3. Rating Scale

Rating	Description
Improved	Less negative behavior, such as agitation, impulsiveness, refusal to eat; and more positive behavior, such as care of self or environment, voluntarily helping others, attending off-ward activity.
Improved with relapse	Same signs of improvement with return to former state after one month but before three months have elapsed.
Slightly improved	Less negative behavior, very little positive behavior.
Unimproved	No change in previous behavior.

Improvement shown by each diagnostic category is listed in Table 4.

Table 4. Improvement by Diagnosis

Diagnosis	No. in group	Improved	Improved with relapse	Slightly improved	Unimproved
Schizophrenia, undifferentiated	9	5	2	2	0
Schizophrenia, paranoid	3	0	0	1	2
Schizophrenia, catatonic	3	1	1	0	1
Schizophrenia, hebephrenic	1	0	0	0	1
Manic-depressive psychosis	1	1	0	0	0
Involutional with paranoid ideation	1	1	0	0	0
Total	18	8	3	3	4

To gauge the attendant reaction to the conferences, four questions were asked of those who had attended the sessions. Table 5 lists the questions, grouping and breakdown of replies.

Discussion

No attempt was made to analyze the effects of the individual attendant's personality on the patient's improvement or lack of improvement. No other therapeutic measures were eliminated during the test period. Attention was centered on the effect of

Table 5

Questions	Yes	No	Undecided	Comments
1. Did conferences about individual patients help in your ward management?	6	4	1	
2. In what way might such conferences be improved?				2. (a) Give more of patient's history (4 replies) (b) Hold more conferences (c) Impress patient with the need to co-operate (1 reply) (d) Have longer conferences (1 reply)
3. Were such conferences of any value to you?	8	3	0	3. (a) Helped in understanding patient, winning his confidence and noticing any change in his condition.
4. Do you think such conferences of any value to patients?	7	4	0	

interaction within the attendant group and interaction between the attendant group and patient group on the ward, in order to judge whether such interplay had any beneficial effect on the patient's ward adjustment.

The fact that more of the patient's history was thought to be of value in management and patient socialization is of interest, since such a history contains information about previous occupations, hobbies and leisure activities.

Morimoto and Greenblatt[4] conducted interviews with ward personnel and families concerning the patients' leisure-time pursuits. They found the personnel were aware of only 23.3 per cent of the patients' pre-illness leisure-time activities.

The Wayne County attendants felt that knowing more of the patient's history would give them some leads in their attempts to bring about socialization of the patient.

The attendants credited the conferences with improving their relationships with the patient. None noted the change in his own emotional attitudes, even though, in group sessions, each noted the changes in attitude and behavior of his colleagues.

Since attendants participated in group conferences centering about the adjustment of patients, both from their own wards and

from wards other than their own, they became aware of varying types of problems and differing methods of management used by other attendants.

Now that tranquilizing drugs have made some patients more accessible, the assuring of proper attitudes of attendants and reactions uncluttered by many unconscious distortions are of utmost importance.

People who work constantly with mental patients should be as free from misconceptions and prejudices as possible. The method discussed in this paper merits further investigation as a means for bringing about such a desirable atmosphere.

Conclusions

1. Eighteen patients of mixed diagnoses had their ward adjustment reviewed in group meetings of doctor, nurse, and attendants. The majority of the patients (14) showed some improvement in their ward adjustment for at least a month. Eleven showed improvement that persisted for a longer period. Four were not affected by this program.

2. A slight majority of the attendants answering the questionnaire thought that the conferences had helped in their ward management of patients.

3. The majority felt the conferences helped them understand the patients and win their confidence.

4. None noted that any benefit in working out personal conflicts was derived from the conferences.

5. Results show that group meetings with attendants, using a patient's adjustment as a point of discussion, help attendants appreciate the disturbance in the patient's personality and understand some of the reasons for his peculiar behavior.

Summary

Group psychotherapeutic methods were applied in conferences with attendants in a building for chronic patients.

The effect on patient-attendant interaction was evaluated.

Improvement in patients' ward adjustment was measured.

The personal value of conferences to attendants was assessed.

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REFERENCES

1. Graeber, M. P.; Brown, G. C.; Pillsbury, R. M., and Entertine, I. D.: Group therapy on an acute service. Am. J. Psychiat., 110:677-680, March 1954.
2. Klapman, J. W.: Common sense group psychotherapy for mental hospitals. Dis. Nerv. Sys., XVI: 24-29, January 1956.
3. Middleton, J.: Prejudices and opinions of mental hospital employees regarding mental illness. Am. J. Psychiat., 110:133-138, August 1953.
4. Morimoto, F. R., and Greenblatt, M.: Personnel awareness of patient's socializing capacity. Am. J. Psychiat., 110:443-447, December 1953.

INCREASED CITIZEN SUPPORT FOR THE UTILIZATION OF THE COMMUNITY MENTAL HEALTH SERVICES ACT*

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The "First Annual Mental Health Forum of New York State" also commemorates a golden anniversary. It was 50 years ago that the State Charities Aid Association established its Committee on the After Care of the Insane. The archives show that as early as 1890—16 years before formal organization of this committee—the State Charities Aid Association helped to promote legislation for care and maintenance of the mentally ill; but it was the formation of the committee in 1906 that marked the beginning of continuous and organized effort by citizens of the state on behalf of the mentally ill. It was only four years ago, in 1952, that the citizens' mental health movement in this state assumed its present structure of an independent, autonomous, state-wide organization and became a state member organization of the National Association for Mental Health, which represents, on a national level, a realignment of citizen mental health effort.

The national association, of course, takes pride in its early history, particularly in the courage, vision and dedication of Clifford Beers who founded the National Committee for Mental Hygiene in 1909—three years after the first State Charities Aid Association mental health committee was organized.

It is fitting, therefore, that at the first mental health forum of New York State we pay tribute to the early citizen leaders to whom we owe so much, and draw from their experience an inspiration to face the tasks of the present and future, which will now be discussed.

What the writer considers to be the unique role of citizens in the mental health movement can best be shown by considering the entire movement to be comprised of three main parts:

The *first* part comprises the direct diagnostic and treatment services available to individuals and groups under non-governmental auspices. This would include in any community all the services by physicians, psychologists, social workers, nurses, occupational therapists, rehabilitation counselors, and so on that

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are available in private or non-profit clinics and hospitals, or in the offices of private physicians. It does not include any such services that are directly operated by federal, state or local governments.

The *second* grouping includes all services of whatever variety that are offered by governmental, tax-supported clinics, hospitals and other agencies.

The *third* group includes the services and activities of voluntary citizens' organizations, best exemplified by a county mental health association. In the main, these do not include diagnostic and treatment services. Rather the emphasis is on broad scale educational and preventive services and research.

As one might expect, it is this last segment of community mental health forces that will be the principal subject of discussion here. There will be an attempt to show how the citizen phase of the mental health movement relates to the movement as a whole, with special attention paid to the responsibilities that the citizens' movement in this state has to the governmental operations under the Community Mental Health Services Act.

First, it is desirable, however, to raise some points briefly about the relationships between a mental health association and the private, non-governmental agencies in its community, which provide direct services for the prevention, diagnosis and treatment of mental illness. This is itself a big subject, but discussion will be limited here to a listing of a few of the fundamentals which, in the writer's opinion, must be observed if these two separate and distinct parts of the mental health movement are to make their most effective contributions to the movement as a whole, as well as to each other.

Most important of these considerations is a constant recognition by each group of its own unique responsibilities and areas of competence. While both have the same ultimate objectives, they have separate and distinct tasks to perform. Direct service agencies, indeed the entire psychiatric profession, and all of the allied professions, can function most effectively in communities where the public is aware of the nature and extent of mental health problems. It is the job of the citizens' mental health association to find out what community mental health needs are, and to inform the public of these needs, of the existence of private, nongovernmental agencies in the community, and of how to use

them wisely. The citizens' mental health association can do much also to interpret to the community the vital role of the private practising psychiatrist and his medical colleagues.

The direct service agencies have special obligations to maintain high standards of professional service and to stimulate the upgrading of substandard services in allied agencies. It is not the job of the citizen groups to set standards, but it is their job to educate the public to expect and demand a high quality of service, while at the same time seeing that the public knows how difficult it is, in a society as highly competitive as ours, to maintain high quality.

The mental health association, through a broad campaign of public education and information, must create a community climate in which the service agencies can function with increasing effectiveness. It is the job of the mental health association to lead the public to an ever-increasing understanding that mental illness is not shameful and that a neurosis or psychosis is not a personal disgrace.

Sometimes a mental health association may actually operate a clinic as a pilot, or demonstration, project. If it does so, it should not lose sight of the fact that its main purpose is education of the public. A demonstration is education by deed, as well as by word. It is primarily education, although it may provide critically-needed services. The mental health association, instead of actually operating a clinic, may, of course join with other private, voluntary agencies in helping to organize one.

The fundamental policy to be observed by the mental health association, is that its unique and vital responsibility is education —not providing services. Therefore, once a demonstration of a clinic has accomplished its original purpose of showing a community what a clinic can and cannot do, the association should relinquish the direction to others, for continuance on a permanent basis. If the mental health association continues to operate a clinic on a permanent basis, two unfortunate results are certain to ensue. First: other educational jobs will necessarily be postponed, entirely neglected or, at best, dealt with inadequately. Second: The clinic itself will not be able to expand and improve as it should, because of the limitations, financial and otherwise, of the mental health association.

One may now consider the relationships that should properly

exist between mental health association and official (governmental, tax-supported) groups—with special reference of course to community mental health boards.

Putting it very simply, it is the job of the voluntary mental health association to help government to do a better job in its mental health work. This concept of the role of a voluntary agency is uniquely a part of our democratic way of life in America. Voluntary health agencies are part of American generosity, part of our genius for *doing* something about problems, rather than talking about them. They are part of the American pioneer heritage which makes it abhorrent for us to wait for something to happen—instead of making something happen.

In addition to helping government do a better, more comprehensive job in mental health work, it is also the job of a citizen mental health organization to represent citizens generally in saying to public officials and legislative bodies just what, when, and how much activity they feel government agencies should assume in mental health work. In other words, it is not the function of mental health associations to assume blandly that all expansions in, and all additions to, government mental health services, are good. Rather, citizen groups should determine wisely and objectively what is appropriate for government to do, and what should be reserved for citizens to do themselves through voluntary agencies supported by voluntary contributions. Related to this is the responsibility of the citizen's mental health association of making informed recommendations as to what part of the tax dollar should be allocated to government mental health work.

Now, let us apply these broad principles to the specific task of developing increased citizen support in New York State for the utilization of the Community Mental Health Services Act.

In surveying the extent to which county governments throughout the state have taken action to establish community mental health boards, and in measuring progress in this regard in terms of the percentage of the state's total population now being served by community mental health boards, there may well be a sense of pride and satisfaction. But one must realize that, despite the fact that the counties now having community mental health boards represent over three-quarters of the state's population, the remaining 25 per cent of the population is dispersed over 42 counties. In each of these counties, citizens are failing to receive

benefits to which they are entitled under the Community Mental Health Services Act—benefits which their state taxes are helping to provide in other counties! This is a situation that is a "natural" for a mental health association—a natural opportunity for a voluntary agency to take the initiative in making things happen.

At this point, it is appropriate to point out that many of the counties which do not have community mental health boards also do not have voluntary mental health associations. This is a regrettable combination of circumstances and one which the state society has resolutely determined to change as rapidly as practical.

Nevertheless, it is not meant to imply that county mental health associations have a monopoly on the function of providing citizen leadership for the establishment of community mental health boards. In the absence of a county mental health association, other citizen groups can and should take the initiative. However, it is the writer's firm conviction that this is a job for which properly-organized mental health associations should be better-equipped than any other citizens' groups.

But just how does one go about bringing into being a community mental health board? The steps are fairly clear-cut and direct.

First, let the writer point out what he considers to be the least desirable way of bringing a community mental health board into being. Actually all that is required is for the county board of supervisors to pass a local law and appoint the board. Ideally, though, even assuming that the board of supervisors is thoroughly familiar with the long-range obligations it is assuming by such action, and even though its members may be enthusiastic and eager to have the board established, the writer submits that it is unwise to do so without first testing public opinion about it, and preparing the public for the action. Do the citizens, whose taxes are going to have to support the board, understand why it is needed? Do they know what kind of services it can and should provide for them? Are they willing to see these services expand with time, and are they willing to foot the tax bills which will be required to pay for them?

A community mental health board which is "sprung" on a community without a preliminary campaign of public information and education, faces a handicap from the start. A new board is going

to need broad public understanding and support and this should be assured to a large extent before a Board is created.

It would be well to consider just how this advance understanding can be achieved:

First, a group of citizens, preferably the board of directors of a county mental health association, perhaps acting through a special citizens study committee, should make a careful analysis of the Community Mental Health Services Act itself. They should understand the broad objectives of this far-reaching legislation. They should become intimately familiar with its main provisions.

The next step is to study the provisions of the act as they relate to the county concerned. While counties in New York State are more alike than different, there are enough differences from county to county to make this an essential step. Usually, this study will require the technical assistance of someone thoroughly familiar with the local county government structure and operations. This may be the county attorney, a member of the board of supervisors or some other public official, or it may be any other citizen who has had occasion to familiarize himself thoroughly with the intricacies and vagaries of county government.

The need for this kind of assistance cannot be emphasized too strongly, for more than one instance can be cited in which citizen groups, although well informed on the broad provisions of the act and well briefed on the local needs which a community mental health board would serve, suffered disappointment and setbacks in their efforts to get a board established because they were unaware of the importance of some relatively minor clause in the law, some legal interpretation of it or some local governmental restricton. It goes without saying, of course, that the technical adviser must be sympathetic with the objectives of the group. If not, the advice he renders can effectively discourage and thwart their efforts by presenting only obstacles, and failing to point out legal and appropriate ways for removing them, or circumventing them.

The citizens' group, then, which presumes to set for itself the task of establishing a community mental health board must, therefore, first become expert in knowledge of the state act and its local application. Having satisfied themselves that they qualify as "citizen experts" on the Community Mental Health Services Act and its implications for their own county, the members must then face

the task of extending a large portion of their understanding to the public as a whole. They must test public reaction to the idea. They must substantiate their convictions about the need for a board with facts. All this calls for an intensive, carefully-planned campaign of fact-finding and public information.

A campaign need not involve a highly technical, painstaking survey. Rather what is called for is a fairly quick pulling together of readily available facts such as: (1) the number of county residents who are patients in the state hospitals for the mentally ill; (2) the number of county admissions and discharges to such state hospitals for the preceding year; (3) the case load of psychiatric clinics—if they exist; (4) the children's court case load; (5) the county divorce rate; (6) the number of children in foster homes; (7) the county crime rate and juvenile delinquency rate; (8) data on adoptions; and (9) the need for psychiatric facilities, as estimated by clergymen, school officials, social agencies and others to whom people turn for help.

The writer would be one of the first to admit that it is extremely difficult to acquire valid statistics about mental health needs, particularly by resorting to "nose counting" surveys. Nevertheless, a considerable amount of information can and should be accumulated. Wisely interpreted, this can form strong presumptive evidence on mental health needs.

Actually, the need for a psychiatric clinic, for example, is best proved by establishing one. To the writer's knowledge, there is literally no psychiatric clinic in any community which, if properly organized and staffed, does not have difficulty in handling all the patients who come to its doors.

This preliminary campaign of fact-finding and education then will depend—justifiably, the writer would say—on subjective evidence and on the opinion of informed community leaders and groups. Major emphasis should be placed on the kinds of essential, basic services which a community mental health board would bring to the community.

Persuasive arguments must be advanced as to the need for an aggressive approach to the problems of mental illness.

The techniques of such a campaign do not need elaboration here —nor does space permit it. Suffice it to say, that it will require planning and careful timing, that all important community leaders and groups should be involved, that there should be extensive use

of group meetings and mass media, and that it should be pointed toward the specific action required of the board of supervisors—the enactment of a local law to establish the community mental health board and provide an adequate initial appropriation.

The writer would now like to invite attention a little more specifically to the kind of ideal relationship which should exist between a county mental health association and a community mental health board, once it has been established, following a well-conducted, vigorous campaign of public information and education. It is highly desirable, of course, for establishing the right kind of relationship between the voluntary mental health association and the community mental health board, that the voluntary association have a part in bringing the board into being, and have a part in creating the climate of public opinion most likely to assure its success. This does not mean, of course, that where a community mental health board has preceded the establishment of a county mental health association, the county association is no longer needed. Rather, the new county mental health association is faced with the responsibility of bringing together the already existing interested citizens and groups and binding them into an effective county-wide organization that provides for a maximum of citizen participation.

It was said before that the job of the voluntary mental health association is to help government do a better job in mental health work. That is, it is the responsibility of the citizen's organization to help decide just what it wants the government mental health agencies to do, and to exert its influence in a co-ordinated, effective and statesmanlike fashion. Although this is a tremendous responsibility, it, nevertheless, simplifies, in a way, the objectives of a voluntary association. It places a high premium on co-operative enterprise and sound public relations.

To do this phase of the job effectively, the voluntary agency must realize that if it is to be of material help to the official agency, it must be very strong itself, strong in citizen-leadership, organization, and administration, and in the services of qualified personnel. In short, it must be the kind of agency that has earned the respect and confidence of citizens generally, and more particularly of the official agencies in the community.

This leads directly to another thought which needs emphasis, and it is this: Although the voluntary agency accepts the role of

assisting government to do a better job, it in no sense of the word accepts a subservient role in doing so. Indeed, when both agencies are strong, there is no need whatever for one to dominate the other. An attitude of mutual respect and confidence will prevail.

This does not eliminate the possibility that occasions may arise when the voluntary agency will have to criticize the official agency publicly. If it does so, it should do so from a position of strength, with the welfare of the entire community in mind, and—perhaps more important than anything else—with a willingness to help correct the situation that has called for the criticism. In this connection, one may quote Louisa Lee Schuyler, a founder of the State Charities Aid Association, who had this to say about criticism of official agencies by citizens' groups:

"Our work, based upon the education of public opinion, is at once the slowest as well as the surest kind of reform work. It invites cooperation, but it also invites opposition. We never fight unless necessary, but when we do fight we keep on, sometimes for years; and we always win in the end."

The writer would like now to list for consideration a few guiding principles which, he maintains, will develop the kind of strong alliance between official and voluntary agencies which is necessary if they are to serve their communities with maximum effectiveness.

The first of these is that a prime responsibility of the mental health association is to meet its obligation effectively to inform the public about the nature and extent of mental illness, to remove stigma and shame from mental illness, to tell people what to do and where to go for help with mental health problems, and to tell them what they have a right to expect by way of mental health services from their government.

Second, a mental health association has a clear obligation to advocate legislation either locally, on a state level, or in Congress, which will enable government to provide the services which citizens have a right to expect.

Third, and perhaps most important of all at this stage of development, it is a job of the voluntary agency to see that the necessary public appropriations are made so that the community mental health board can provide the proper kind of facilities and personnel. One may expand briefly on this point. It is easy to demonstrate with figures the tremendous cost of mental illness to our state and local government. It is also easy to talk convincingly

about the fact that efficient and aggressive handling of the problem of mental illness will ultimately result in long-term economy. However, it must be said, and said unequivocally and with strong conviction, that for some time to come the surest way to save money is to spend more money now. There is a wise economy in large, adequate appropriations for dealing with a problem as large as mental illness—which frankly, has not been dealt with adequately thus far.

The next point is that the voluntary association has a unique responsibility to demonstrate new lines of work, to show their need and value to a taxpaying public. The writer points here with pride to the success of the state society in demonstrating the need and value in state hospitals of directors of volunteers.

Next, the voluntary agency is well equipped to interpret the services of official agencies to the public, thereby increasing public understanding, and good will, and moral and financial support for the official partners.

Next, it is the responsibility of the local mental health association or the state association, to offer constructive suggestions, based on the organization's own study and analysis, for changes in policies and procedures which will lead to improvement when services are weak, inefficient and neglected.

The next and final point in the list is the reverse of the one just mentioned. The voluntary agency should always be ready to "go to bat" in the support of efficient government service when it is unfairly attacked or when its appropriations are threatened.

In summary, therefore, let it be said that official and voluntary agencies are allies and co-workers, with the common objectives of the prevention of mental illness and the care and treatment of those suffering from it.

This is the kind of relationship which should grow stronger with each passing year; and this places a real responsibility on the New York State Society for Mental Health and its member organizations. The society will, as quickly as possible, need to get on with the job of completing its state-wide organization. It will need to imbue its program plans with flexibility, imagination and creative energy. It must pay adequate attention to the internal problems of fund-raising and organization, but keep them in perspective and not allow them to claim an undue proportion of time and attention.

The organization's history under State Charities Aid Association leadership, particularly since it has been a society, has shown that it can make imaginative and creative contributions to government's mental health programs. The coming decade is filled with unprecedented opportunities which, if properly met, will be more rewarding than anything in our past history. Let us put aside the minutiae and things which tend to slow up our growth and retard our effective leadership. Let us make our objectives nothing less than the relief of hundreds of thousands of citizens from the terrors and handicaps of mental illness. Let us resolve that whatever it costs in money or in voluntary effort, we will press firmly toward these objectives. With our eyes set on these broad, admittedly distant and difficult objectives, we can nevertheless face the future with banners flying.

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A PSYCHOLOGICAL NOTE ON F. SCOTT FITZGERALD AND HIS NOVELS

BY ABE J. JUDSON, Ph.D.

Fitzgerald once jotted down this little paragraph about himself:

"I didn't have the two top things: great animal magnetism or money. I had the two second things, though: good looks and intelligence. So I always got the top girl."[1, p. 211]

We may not share Fitzgerald's values, and even if we did, it is unlikely that we would regard the possession of these four "top things" exclusively as a means of obtaining the "top girl." For most of us, the last line in the quotation is a *non sequitur;* for Fitzgerald, it was a logical conclusion, because getting and keeping the "top girl" was, if we may judge by his work, something of an obsession with him. The bare, matter of fact, dogmatic lines quoted provide a link between an important facet of Fitzgerald's character and a dominant theme of all his novels. In this paper, there will be noted the presence of this need for the female love object in his novels and some suggestions will be offered about the meaning and origin of the need.

A good part of *This Side of Paradise,* his first novel, is devoted to Amory Blaine's affairs with Isabelle and Rosalind. After losing Isabelle, Amory fails to make good a scholastic deficiency, which puts an end to his aspirations of becoming a "big man" on the campus. Amory believes there is some connection between these two blows because "somehow, with the defection of Isabelle, the idea of undergraduate success had loosed its grasp on his imagination,"[2, p. 105] and he wonders unhappily "why all the color and ambition of the spring before had faded out."[2, p. 105]

After leaving college and serving in the army, he meets Rosalind, with whom he promptly falls in love. Rosalind eventually feels compelled to end the affair because Amory, once wealthy, is now virtually penniless, has only a $35-a-week job, no prospects, and can't possibly support her in a suitable manner. For Amory, Rosalind had been "life and hope and happiness, my whole world now."[2, p. 200] With the loss of Rosalind, his world is shattered, and he goes on an epic three-week drunk. Amory at one point voices radical sentiments because he's "sick of a system where the rich-

est man gets the most beautiful girl if he wants her."[2, p. 299] The book ends on a faintly affirmative note; Amory will try to make use of his abilities, he will try to achieve some success, but "it's all a rather poor substitute at best."[2, p. 304] Amory's feelings toward Rosalind and his reaction to her loss are not, of course, unusual. They take on significance only in the light of the subsequent novels.

Fitzgerald's second novel, *The Beautiful and Damned,* is primarily concerned with the early years of a marriage. Anthony Patch, a dilettantish, ineffectual young man and presumed heir of a fabulously wealthy grandfather, leads a bored, empty life until he meets Gloria Gilbert. She quickly becomes the center of his existence and when, after an argument, their affair is temporarily broken off, Anthony feels that he received "the hardest blow of his life. He knew at last what he wanted, but... it seemed ... forever beyond his grasp. She had sent him away! That was the reiterated burden of his despair."[3, p. 115] Anthony feels that "he must own that strength that could send him away."[3, p. 116]

They eventually marry and lead a rather disordered, hectic and expectant life, waiting for Anthony's huge inheritance. Anthony, although by no means completely dependent upon Gloria, does look to her for support. "Whenever that overpowering terror of the night attacked Anthony, she would croon, 'I'll protect my Anthony, oh nobody's ever going to harm my Anthony!' "[3, p. 160] And he feels that if he lost her, he would be a "broken man."[3, p. 277]

While in an army training camp, Anthony has an affair with another girl. He returns to Gloria after the war, and when—in the midst of a legal battle over his inheritance—his ex-mistress suddenly shows up at his home, prepared to resume the relationship, Anthony goes berserk and becomes psychotic. He finally gets his money but is not yet recovered from his illness at the close of the book.

Although the return of his mistress was not solely responsible for his psychotic episode—Anthony was becoming an alcoholic, the inheritance seemed lost, and he and Gloria were tumbling rapidly down the socio-economic ladder—it was obviously the precipitating factor. And it would appear to have pushed Anthony over the edge of sanity, because her return would surely have meant the loss of Gloria.

These first two novels are perhaps too meandering to permit the theme of the hero's need for the girl to emerge with clarity.

In *The Great Gatsby*,[4] however, the theme is the core of the novel; for Gatsby is concerned with nothing but his dream of finding and possessing his lost girl, and all his efforts are directed to shaping the world to fit that dream. He lost Daisy to Tom Buchanan because he was poor; if he is to win her back he must have money. He manages to make a huge income by engaging in various illegal enterprises. He buys a mansion near her home and gives fantastic parties in the hope that Daisy will attend one of them. He finally does meet her, but the affair speeds to disaster rather than fulfillment. Daisy accidentally runs down and kills her husband's mistress while driving Gatsby's car; and Gatsby is, shortly thereafter, shot to death by the dead woman's husband.

After Daisy's marriage to Buchanan, Gatsby had been sustained by the conviction that given money and a second chance, he could win her back. He got his money and his second chance, but not Daisy. Before Gatsby's death, Fitzgerald makes it perfectly clear that Daisy will stay with Tom. The loss of Daisy means the end of his hope, the end of his dream; it is psychological death. Deliberately or unconsciously, Fitzgerald points up and symbolizes this spiritual death by Gatsby's physical death.

Dick Diver, the hero of *Tender is the Night*, is a young and brilliant psychiatrist who, at the outset of his career wants to be "a good psychologist—maybe the greatest one that ever lived"[5, p. 225] but the novel tells the story of his deterioration. His failure is intimately bound up with his marriage to Nicole, a temporarily-recovered schizophrenic patient who has fallen in love with him and with whom he has had an informal therapeutic relationship. He marries her despite the warnings of his colleagues and his recognition that the marriage will interfere with his career. After his marriage and career have been wrecked, Dick understands why he has sacrificed his career for Nicole: "he had made his choice, chosen Ophelia, chosen the sweet poison and drunk it. Wanting above all to be brave and kind, he had wanted, even more than that, to be loved. So it had been. So it would ever be . . . ."[5, p. 330] Despite his intense need for achievement, Dick's need for the girl is even greater. In his notes for the novel, Fitzgerald explicitly recognizes Dick's need by pointing out that among Dick's faults is "the desperate clinging to one woman."[6, p. 310] Although the processes that are to undermine Dick are formally set in motion when he first meets Nicole, and his disintegration is well under

way while still married to her, it is only after he has lost Nicole that his failure is complete. While with her, he maintains his economic position, and at least partially, his social and professional standing. All three are lost after the divorce, when he becomes a rather disreputable general practitioner, drifting from one central New York town to another.

Fitzgerald was working on his last novel, *The Last Tycoon,* when he died in 1940. The last tycoon is Monroe Stahr, a Hollywood producer, and the novel was to deal with the final phase of Stahr's life.

Stahr has been a hollow man since the death of his wife, Minna. Without her, he has no desire to live. He accepts with equanimity the idea of his own imminent death because of a bad heart, and indeed, attempts to hasten the end by driving himself at his job. One day, he catches a glimpse of a girl who bears a remarkable facial resemblance to his dead wife. Somehow, with her, he can begin to live again. He manages to meet her and recovers the zest for living that had been absent since Minna's death.

According to his notes, Fitzgerald intended to dramatize a struggle for Hollywood power; but not surprisingly, "the meat of the book"[7, p. 139] was to be the love story. In one sense, *The Last Tycoon* is a variation of the Gatsby theme. Gatsby searches for his original love; without her, life is meaningless. Stahr's original love is dead and, emotionally, so is he; he searches for the girl, the reincarnation of Minna, who will restore him to emotional life.

These five novels, written over a period of 21 years, show certain remarkable similarities of theme. In each one, the urgency of the hero's need for the female love object plays a dominant or important role. In each novel, too, loss or the threatened loss of the love object has a shattering effect upon the hero. Amory Blaine loses Rosalind and goes into an alcoholic stupor; life has lost freshness, charm and glory. Anthony Patch becomes psychotic when he is threatened, by the return of his ex-mistress, with the loss of Gloria. Jay Gatsby's death follows hard on the heels of the revelation that his dream of marrying Daisy is not to be realized. Dick Diver is divorced, and he sinks into oblivion. Monroe Stahr loses Minna, and he waits quietly for death until Minna is reincarnated in the form of Kathleen. It seems unlikely that a theme so regularly and variously expressed could fail to be a projection of a similar

need of the author. Why is this pattern of love and the consequences of the loss of love such an insistent one in Fitzgerald's novels? Fitzgerald's early experiences in his family are responsible, one may believe, for the development of his need for the "top girl."

Fitzgerald's mother's family was fairly wealthy but his father, although related to some distinguished American families, was poor and, according to Fitzgerald, a failure in life. The father seemed to have had little talent for business, and the financial position of the family progressively worsened during Fitzgerald's early years. As his economic fortunes declined, Fitzgerald's father's drinking increased. Although ashamed of his father's economic and alcoholic weakness, Fitzgerald loved him, identified with him, and was unhappy whenever his father suffered some new humiliation. In 1908, the father, who had been working as a salesman for Proctor and Gamble, was fired and "thereafter lived almost entirely on his wife's money."[8, p. 183] Fitzgerald at the age of 40, has a clear recollection of the event.

"One afternoon—I was ten or eleven—the phone rang and my mother answered it. I didn't understand what she said but I felt that disaster had come to us. My mother, a little while before, had given me a quarter to go swimming. I gave the money back to her. I knew something terrible had happened, and I thought she could not spare the money now.

"Then I began to pray, 'Dear God' I prayed, 'please don't let us go to the poorhouse; please don't let us go to the poorhouse.' A little while later my father came home. I had been right. He had lost his job.

"That morning he had gone out a comparatively young man, a man full of strength, full of confidence. He came home that evening a broken man. He had lost his essential drive, his immaculateness of purpose. He was a failure the rest of his days."[6, p. 246]

The family didn't go to the poorhouse. They returned to St. Paul, where, with the help of Mrs. Fitzgerald's family, they became established in an upper middle class neighborhood. It was the mother who, in effect, not only saved the family, but gave it substance and solidity. In the eyes of the young boy, they might well have been disgraced and lost had the mother not saved them. Mrs. Fitzgerald's protective role may have been enhanced by her

indulgent treatment of her child. Fitzgerald said of her that "I didn't know till 15 that there was anyone in the world except me."[6, p. 3] Fitzgerald's maternal grandfather had died at an early age, and his maternal grandmother, with her impressive home in an exclusive neighborhood, may have reinforced his developing conception of the protecting mother figure.

With this background, Fitzgerald could hardly avoid perceiving his mother as the source of strength in his family. Almost certainly, his early years, before the telephone incident which has been related and which had such a powerful impact on him, contributed to this conviction of his mother's power and his father's weakness, for he had seen his father snubbed and humiliated by other men and living "always in mother's shadow."[6, p. 12]

Fitzgerald's intense need for the female love object appears then, to have had its roots in his early family life. The powerless father was saved from destitution by the mother's resources. The son, identifying with the father he loved (and therefore weak and helpless), must find a strong protecting girl to save him from a similar fate. The end of Fitzgerald's heroes, after the loss of their love objects, is the end that would have overtaken his father had he lost his wife. It is the end to which he saw himself doomed if he did not have his own protectress. Like Anthony Patch, Fitzgerald felt that he had to "own the strength" of the girl he loved. Fitzgerald's great fear was the loss of the protecting mother figure. His need for the "top girl," the substitute mother figure, stems from this fear.

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REFERENCES

1. Fitzgerald, F. Scott: The Crack-Up. Edmund Wilson, editor. New Directions. New York. 1945.
2. Fitzgerald, F. Scott: This Side of Paradise. Scribner's. New York. 1920.
3. Fitzgerald, F. Scott: The Beautiful and Damned. Scribner's. New York. 1922.
4. Fitzgerald, F. Scott: The Great Gatsby. Scribner's. New York. 1925.
5. Fitzgerald, F. Scott: Tender is the Night. Viking Portable Library Edition. Viking. New York. 1945. (Originally published by Scribner's, 1934.)
6. Mizener, Arthur: The Far Side of Paradise. Houghton Mifflin. Boston. 1951.
7. Fitzgerald, F. Scott: The Last Tycoon. Edmund Wilson, editor. Scribner's. New York. 1941.
8. Piper, H. D.: F. Scott Fitzgerald and the Image of His Father. Princeton Univ. Lib. Chron., XII:181-186, 1951.

THE TASK OF THE PSYCHIATRIST AS CONCEIVED BY JOHANN CHRISTIAN A. HEINROTH

BY ERNEST HARMS, Ph.D.

In a period when the need to map the basic areas of psychiatry and their adjacent and overlapping territories can no longer be avoided, it is worth while to turn to the early years of the past century. For it was then that the scientific psychiatry we know today had its beginnings.

Benjamin Rush wrote the first American textbook of psychiatry in 1789. In its first paragraph, he speaks of "treading on consecrated ground in wanting to attempt to lessen a portion of the greatest evils of human life." Although not many today will agree with the formulations of the Quaker doctor of Philadelphia, his words carry the ethical strength of a psychiatric Hippocratic Oath.

Rush's *Medical Inquiries and Observations on the Diseases of the Mind* lacked a systematic scholarly quality. Two decades after his book appeared, however, the German psychiatrist, Johann Christian A. Heinroth, published two volumes on the subject of *"Psychische Heilkunde"* (psychotherapy), which was the first really systematic textbook of psychiatry.

Heinroth was an amazing "universalist" of the Wilhelm von Humboldt type— of whom only a very few have ever lived. He was born in January 1773, the son of a Leipzig physician. As a young boy, he showed prodigious abilities in the arts and languages; but, after graduating at the head of his class, he decided to follow his father's profession. Then, after he had completed his medical studies with the highest honors, he suddenly turned to a study of theology. This choice was not unanticipated, since, as a secondary school student he had published several papers dealing with theology which had received considerable attention. Nevertheless, three years later he turned to medicine again, with a distinct interest in psychiatry. From an assistant professorship in medicine, he rose in 10 years to head his school's department of psychiatry; and after another decade, he became dean of the medical school of the University of Leipzig. In addition, he was a member of the theological and law schools of the university and taught courses in them from time to time.

Heinroth's fame as an academic lecturer, though great, was sur-

passed by his ability in writing scientific textbooks. There were few fields within reach of his interests in which he did not contribute basic books which remained in use for decades. There were such works on general physiology, anthropology, general pathology, psychopathology, psychotherapy, and criminal psychopathology. He wrote a book against homeopathy, and another on psychological mistakes in education. There was also a criminology, entitled *The Lie,* and a psychology with the title *Psychologie als Selsbsterkenntnis-Lehre.* Besides this, he published several novels and a great deal of poetry under a pseudonym.

Heinroth's most important book is his *Lehrbuch der Störungen des Seelenlebens,* which appeared in two volumes in 1818. It was the first textbook of psychiatry. He was the most prominent representative of the so-called school of psychological psychology, of which the two other leaders were Reil and Neumann.

Heinroth's basic thesis was that abnormal psychological facts should not be defined from hypothetical constructions, but should be observed and diagnosed as psychological phenomena. He rejected the "*Nervensaft*" and the other physiological theories of the eighteenth century. As his years of theological study show, Heinroth was a highly religious man; and his religious faith had its effect on his attempts to make a strictly scientific approach to psychological facts. From his combination of interests, grew his belief that participation in a sound religious life is important in preventing mental abnormality and in helping the mentally diseased. However, as the writer has shown elsewhere in Heinroth's own words,* he separated medical psychology altogether from clerical counsel. This position has not only been the basis of misunderstanding but has been the major target of his critics.

Heinroth became the chief object of attack by the school of somatic psychiatry. Its followers maintained that there was nothing in the psyche or mind of a healthy or mentally diseased individual which did not result from physical pathology of the brain or the nervous system. Friedreich, whose brilliant pen was the mainstay of the somatists, made Heinroth the butt of his sarcastic polemic, *Historisch-kritische Darstellung der Theorien über das Wesen und den Sitz der psychischen Krankheiten* (historic-

*Harms, Ernest: How Heinroth divided the task of the clergyman and the psychiatrist. J. Pastoral Care, X:I, 45-48, Spring 1956.

critical presentation of the theories on the function and location of psychopathology 1836).

Friedreich had great influence as a result of his history of psychiatry. The writer contends that it was a "turncoat" version of Heinroth's own history.* He denounced Heinroth to such a degree that hardly more than his name appears in the history of psychiatry.

On various occasions, the present writer has pointed out that Heinroth was one of the most important forerunners of modern psychiatry. In many respects it is, therefore, worth our while to rediscover his work—not out of sentimental regard for the past but because he expressed thoughts and presented points of view worth reconsideration, provided one takes the fact into account that he lived before either the exact science of physiology of the nervous system or the science of modern psychology was formulated.

There is scarcely a psychiatrist prior to 1900 who measures up to the importance that Heinroth merits. In his *Seelenstörungen* of 1818, there is an introductory chapter on "basic concepts" (*Vorbegriffe*) which contains several paragraphs dealing with the task of the psychiatrist. The clarity of his thought seems to the present writer to make valuable reading material for any modern psychiatric thinker. For this reason, the writer has attempted its translation. In doing so, he has had to interpret and modernize Heinroth's language, which readers accustomed to today's scientific terminology could not find easy to understand. For instance, the term *"psychische Doktor"* has been translated as "psychiatrist." At one point, a line in which Heinroth identified himself with the Protestant theology of his time is omitted. It was felt that this was necessary to avoid a misconception which has become traditional because of a succeeding general attack upon Heinroth's views.

Heinroth's opposers claimed that Heinroth believed all mental illness to be the result of sin committed by the diseased person. The passage translated here will thoroughly disprove this. The actual contents of the sentences on religious life have not been changed. Heinroth's comments here can easily be applied in their original form to pluralistic religious thinking, or even agnosticism

*Harms, Ernest: The Early Historians of Psychiatry. Am. J. Psychiat., 113:8, 749-752, 1957.

in our own time. In many places in the translation, Heinroth's long sentences have been broken up in order to present his thoughts in readable English. Heinroth wrote:*

"Assuming that it is possible to cure mental disturbances completely, or at least cure in part, the following question arises: Since it is a human state of health which must be reinstated, and since abnormal psychic life has to be turned back to normality, is this a task for the physician, clergyman, philosopher, or educator? Each of these professions seems justified in considering itself qualified to exercise some kind of corrective care over abnormal human mental states. It is necessary, therefore, to examine and decide which should be permitted to assume such a task by right of tradition or law, and which should be considered a branch of medical science and art.

"Since we are dealing here with medical science and art, we should believe that no one other than a physician could assume the right to study and treat such disturbances of the mind. Indeed, physicians have exercised this right in their compendia as well as in monopolized practice. (Non-physicians, however, have also written on abnormal mental states; it is well known how much non-physicians have distinguished themselves, especially in England, by their excellent treatment of such conditions.)

"In the way we have described abnormal states of mind in contradistinction to normal ones, based on exact observations of human nature, we have proved that we are dealing with phenomena which cannot be judged in the way physicians have become accustomed to evaluating all diseases. The physicians who are at home only with physical nature are not familiar with these phenomena. This observation concerns their understanding as well as their treatment of this sphere of the mental (or psychic) life. Medical writings in general prove to be completely uninformed about this field. In addition, the point of view and the techniques our medical schools instruct and prescribe for the sickbed are completely different and are separate from those which are methodologically demanded and presented in this textbook. Those doctors, therefore, who, as students being initiated into medical science, have made this disturbance of physical existence their only concern, are not fit for the psychological task.

*Lehrbuch der Störungen des Seelenlebens. Vol. I, p. 43, Chapter 5: *"Begriff des psychischen Arztes."* Page 43. Leipzig. 1818.

"The clergyman, whom we must acknowledge as an influencer of the human soul, is equally unfit for the work considered here, because of his point of view, education, and the scope of his work. His field of activity is the moral nature of man—so long as it exists. This does not hold in cases where it has perished or disappeared for a time. The clergy's concern, therefore, is in a completely different direction than that of the psychiatrists. The philosophers (or, more specifically, the psychologists) have indeed ventured, even if primarily theoretically, into the field of the disturbed psychic life. They should become what up to now they have not been—students or faithful observers of nature—if they wish to achieve something worthwhile concerning the theory of psychic disturbances. In actual fact, this has not yet happened, as we shall point out later. So far as the practical aspects are concerned, one can expect nothing, since they are accustomed only to working at their desks. Such practical action is the purpose of the science of medical psychology, which should teach the art of restoring the disturbed psychic life to normality.

"Far more related is this science and art with that of the educator; even physicians are of the opinion that the cure of psychic disturbances requires something like a re-education. However, the educators have not as yet invented this science and art of re-education, even if it can be found elsewhere. The educator, like the clergyman, can only educate and train the self-directing powers in man, and not re-create them when they can no longer function, or when they have gone out of existence. In addition, the scope of the educator's activity is like that of the clergyman, of such size, and demanding so much strength, that it would not be just to heap a new burden upon the educators, even if they felt they had the ability to carry it.

"The abilities that are necessary have a character—at least in part—that neither the educator nor the psychologist nor the clergyman could possess. In the first place, the psychiatrist must be a physician in the real sense of the word. He must be educated in a medical school and trained as a practising physician, since psychic disturbances are very frequently tied to physical sickness; the former are frequently caused, supported and modified by the latter; and, in many cases, psychic disturbances cannot be influenced except through physical medicine. This makes it imperative that psychiatrists come from the ranks of physicians. We

say specifically that they must come out of these ranks, because psychiatrists should not remain in ranks occupied quite enough by their own physical tasks. The field of psychological medicine is so wide that it absorbs all the strength of a very active man. Furthermore, the psychiatrist needs his own education and outlook, which differentiate him considerably from any physician's work.

"Anyone who wants to become a psychiatrist must, in the very real sense, go into the schools of the psychologist, the clergyman and the educator. He must develop the talent of psychological observation; he must learn to take into account the religious point of view; he must try to live the life of a priest, or of a person guided in his living by religious inspiration. That is, it must be a life lived by reason, as laid down in the religious documents, which means a life in the light of the spirit of truth, in which all is united. Finally, he must train himself in the technique of the educator, and assimilate it into his own field. In the last analysis, however, he must receive training in the use of reason in the special form corresponding to the task of the psychiatrist, since —equally—neither real psychology nor the real art of education is thinkable when it is not guided by the eye of reason. Only fully developed reason can understand psychological disturbances in all their forms, and only reason can cure them if they are to be cured at all."

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REVIEW OF MENTAL HYGIENE AND RELATED LEGISLATION FOR THE YEAR 1957

BY E. DAVID WILEY, LL.B.

There were 7,888 bills introduced into the two houses at the 180th annual session of the New York State Legislature before it adjourned sine die on March 29, 1957. There were over 1,700 reprinted bills, raising the total of the printed bills considered to 9,606. The total—of bills introduced and reprinted—exceeded the number for any year in the past 11, and probably is an all-time high for the legislature. The legislature also exceeded its prior records by passing and sending to the governor 1,357 bills. The governor vetoed 310, and gave approval to 1,047 bills which is the highest number of laws enacted in any year during the past 11.

Legislation in the field of mental health and in closely related fields did not stand out significantly. There were 29 bills to amend the Mental Hygiene Law, nine of which had been submitted as part of the department's program, three of these were labeled budget or administration bills. The remaining 20 bills ranged from proposals to establish a geriatrics division in the Mental Hygiene Department and a proposal to reimburse Manhattan State Hospital employees for Triborough Bridge tolls to a bill to authorize sterilization of certain patients. Only seven of the total of 29, all seven on the department's program, were enacted into law. The other 22 bills either were not passed or were vetoed.

Upward of 40 bills were introduced during the 1957 session on subjects related to mental hygiene. Among these were the legislative programs of the Joint Legislative Committee on Mental Retardation and the Joint Legislative Committee on the Problems of the Aging. Only one of these bills which directly involved the department became law. It is Chapter 1024 of the Laws of 1957, making an appropriation of $25,000 to the department for study and preliminary plans for the development of a New York State Research Institute for Mental Retardation.

Appropriations

The legislature appropriated to the department and its institutions, for all purposes under regular budgetary bills pursuant to

Chapters 31, 33, 34 and 258, a total of $217,693,572. The additional appropriation of the $25,000 to study a research institute for mental retardation was enacted at the very end of the session. These total appropriations thus exceed by nearly $10,000,000 the total appropriated originally by the 1956 legislature, $207,572,032. The 1956 figure was increased to a final total of $221,725,726 by deficiency appropriations at the 1957 session.

The accompanying table shows comparative appropriations to the department and its institutions for the fiscal years 1956-57 and 1957-58.

DEPARTMENT OF MENTAL HYGIENE
Comparison of Appropriations for 1956-57 and 1957-58

Administration	Appropriated 1956-57	Appropriated 1957-58	Increase	Decrease
Personal service	$1,280,569	$1,363,130	$ 82,561	
Maintenance and operation	251,870	259,370	7,500	
Maintenance undistributed informational services	50,600	61,724	11,124	
Total	$1,583,039	$1,684,224	$101,185	
Institutional operations				
Personal service*	$123,930,726	$125,532,257	$1,601,531	
Maintenance and operations*	36,438,386	37,275,680	837,294	
Maintenance undistributed				
Malone Annex-St. Lawrence	23,415	25,346	1,931	
Improving patient facilities, Wassaic	100,000	100,000		
Intensive treatment admission	1,210,770	2,776,942	1,566,172	
Intensive treatment chronic		197,090	197,090	
Day hospital service	166,086	160,484		5,602
Tranquilizing drugs	1,500,000	2,000,000	500,000	
Antibiotics for T.B.	35,000	35,000		
To supplement maintenance and operation for increased cost and essential supplies	50,444	150,000	99,556	
Operation of leased facilities for mentally retarded patients		300,000	300,000	
Operation of state-owned facilities for patients		325,000	325,000	
Total	$163,454,827	$168,877,799	$5,422,972	

* Includes only 50 per cent of appropriations for New York Psychiatric Institute and Syracuse Psychopathic (now Psychiatric) Hospital.

Comparison of Appropriations—Continued

	Appropriated 1956-57	Appropriated 1957-58	Increase	Decrease
Research and special studies				
Epidemiological research unit	$ 138,296	$ 131,979		6,317
Biometric research unit	43,800	46,184	2,384	
Cerebral arteriosclerosis	100,000	100,000		
Senile rehabilitation	119,184	148,112	28,928	
Institutional research projects	1,045,250	1,329,519	284,269	
Research in schizophrenia	200,000	200,000		
Research in child psychiatry	13,668	15,012	1,344	
New York Psychiatric Institute*	799,639	861,016	61,377	
Plans for research institute for mental retardation		25,000	25,000	
Total	$2,459,837	$2,856,822	$396,985	
Training and education				
Tuition, stipends and fellowships	$203,000	$370,000	$167,000	
Training of medical staff	150,000	300,000	150,000	
Training of chaplains	12,000	12,000		
Institute in forensic psychiatry		4,000	4,000	
Syracuse Psychopathic Hospital**	213,440	212,506		934
Total	$578,440	$898,506	$320,066	
Programs				
Aftercare clinics	$ 919,108	$1,135,926	$ 216,818	
Child guidance clinics	443,645	465,746	22,101	
Psychiatric services to correctional institutions	242,526	273,917	31,391	
Mental Hygiene Council	18,000	17,300		700
Assistance in obtaining employment for former patients	15,180	15,180		
Psychiatric guidance to aged	150,000	150,000		
Community care	1,965,300	2,310,000	344,700	
Total	$3,753,759	$4,368,069	$ 614,310	
Total State Purposes Fund	$171,829,902	$178,313,349	$6,483,447	
General State Charges				
State Hospital Retirement Fund	669,783	669,783		

*Includes 50 per cent of appropriation for New York Psychiatric Institute.

**Includes 50 per cent of appropriation for Syracuse Psychopathic (now Psychiatric) Hospital.

Comparison of Appropriations—Concluded

Local Assistance	Appropriated 1956-57	Appropriated 1957-58	Increase	Decrease
Community Mental Health Services	$ 7,620,165	$ 9,346,440	$1,726,275	
Capital Construction Fund				
Capital projects	38,686,000	26,764,000		11,922,000
Rehabilitation and improvements	1,116,191	1,000,000		116,191
Equipment	1,803,685	1,600,000		203,685
Total	$41,605,876	$29,364,000		$12,241,876
GRAND TOTAL	$221,725,726	$217,718,572		$ 4,032,154

Some recent department programs as well as newly-initiated ones, are reflected in the comparative appropriations. Increased support of Commissioner Hoch's intensive treatment program is reflected in the doubling of the amount of 1956-57 appropriation for 1957-58. This program is being expanded from four to eight institutions, and extended to two chronic services of approximately 500 patients each. The tranquilizing drug program is being increased by one-third for 1957-58 over 1956-57. Two new items appear in the 1957-58 budget, which call attention to temporary emergency measures to relieve overcrowding; these are appropriations of $300,000 for operation of leased facilities for mentally retarded patients and $325,000 for operation of state-owned facilities for patients. The appropriations for research and special study were continued in the 1957-58 budget at about the same figures as for 1956-57. It should be remembered, however, that these projects received their greatest support and expansion in the 1956-57 budget when they were doubled and quadrupled in some instances over the amounts allocated in previous years. The department's training and education programs, which were aided and expanded by substantial increases in appropriations for 1956-57, were implemented by further substantial increases for 1957-58. Funds for tuition stipends and fellowships were increased from $167,000 to a total of $300,000. Funds for medical staff training were doubled over the previous year to a total of $300,000. A new item is $4,000 to finance the Institute in Forensic Psychiatry—for personnel giving psychological and psychiatric services to the correction institutions.

Reflecting the trend in recent years for intensified attention

to the release of patients from hospitals and their follow-ups at aftercare clinics, are increased appropriations to the four aftercare clinics serving the downstate area.

The continued growth of the community mental health services program is illustrated by the increased appropriations of $1,726,275 for 1957-58, bringing the total to $9,346,440 to reimburse local government units for the state's share of approved mental health programs. Programs are in force in 14 counties and the City of New York and in the process of development in four counties. These areas include 80 per cent of the population of the state.

Mental Hygiene Law

Department Program Bills

The department's 1957 program of amendments to the Mental Hygiene Law included 10 bills. Seven became law. Two of these were handled through the governor's office, since they were mentioned in his annual message to the legislature. One was handled as a budget bill.

Chapter 785 deletes the terms "poor person" and "indigent person," as well as other phrases and clauses of this character from all sections of the Mental Hygiene Law. This bill became an administration bill by reason of the governor's statement in his annual message: "I again recommend legislation to eliminate from our laws the offensive concept that our mental hospitals are only for the 'poor and indigent.'"

Chapter 361 amends Section 134-a of the Mental Hygiene Law to permit the direct transfer of psychotic mental defectives to Matteawan State Hospital. This section formerly permitted the transfer of dangerous patients in the state schools in the Department of Mental Hygiene only to institutions for defective delinquents in the Department of Correction.

Chapter 546 amends Section 46 of the Mental Hygiene Law in relation to acquisition of real property for a state institution to permit partial payment, where the full value of the land taken cannot be agreed upon between the commissioner of mental hygiene and the owners. This saves owners the long wait for determination by the Court of Claims, and may also save money for the state in eliminating interest on the full amounts of claims between the dates of land-taking and eventual judgment by the court.

Chapter 605 repeals Section 19 of the Mental Hygiene Law which provided for the certification by the commissioner of qualifications of certified psychologists authorized to make examinations as provided in the Mental Hygiene Law; and, in its place, amends Section 2 of the Mental Hygiene Law to define a certified psychologist as one certified under the provisions of Article 153 of the Education Law enacted in 1956, and who, when so certified, is authorized to make the examinations as provided in the Mental Hygiene Law and the Correction Law. It was felt —after the enactment of Article 153 of the Education Law—that certifications of psychologists by the Mental Hygiene Department and by the Education Department were largely duplications and that it would be better that only the Education Department have this function.

Chapter 117 amends subdivision 4 of Section 87 of the Mental Hygiene Law to delete the clause "not exceeding one year" from the last paragraph. This makes the provisions for granting convalescent status by licensed private institutions conform to the provisions for state institutions.

Chapter 434 amends Section 184 of the Mental Hygiene Law to make its provisions conform to the provisions of the Civil Service Law and the Retirement and Social Security Law with respect to the right of a retired officer or employee taking employment in governmental or public service and still being entitled to receive a benefit or annuity under the system. The dollar limits had been raised in the other laws consistent with the rapid change in the purchasing power of the dollar in recent years and the $750 annual earning limit provided in Section 184 and the $1,500 limit computed without optional modification were raised to $1,800 per year and $3,500 respectively.

Chapter 266 amends Section 200-a of the Mental Hygiene Law redesignating Syracuse Psychopathic Hospital as Syracuse Psychiatric Hospital.

Laws Relating to Mental Hygiene

Chapter 791 amends Section 8, subdivision 12 of the State Finance Law to increase the maximum payable as a small claim against the state from $150 to $350, and authorizes payment of

claims approved by the head of an institution in the Department of Mental Hygiene or the Department of Social Welfare for real or personal property damaged or destroyed or for personal injuries caused by any patient during 30 days from the date of his escape from such institution.

Unsponsored Amendments

There were three statutes enacted by the 1957 Legislature directly affecting the department, not sponsored by the department, but approved by the department before enactment.

Chapter 235 authorizes the conveyance of certain lands of Pilgrim State Hospital to the Union Free School District No. 7, Town of Babylon.

Chapter 966 authorizes conveyance to the School District of the Town of Malone the lands and equipment of the Northern New York School for the Deaf, which had been under the jurisdiction of the Department of Mental Hygiene for conversion to mental hospital facilities, a project which never had been found feasible. This legislation in effect took a "white elephant" off the hands of the state and served to meet a very urgent need of the town of Malone.

Chapter 1024, previously referred to, appropriates a sum of $25,000 to the department for studies and preliminary plans for the development of a New York State Research Institute for Mental Retardation.

Defeated Bills

Brief mention should be made of three bills proposed by the department which failed to pass. One bill was introduced as a budget bill because mention of it was made in the governor's budget message as follows: "I am proposing legislation which is expected to make an additional $1.0 million available for these two purposes in 1957-58 by creating a Mental Health Research and Training Fund. The fund would be financed from one-half of the annual increase in revenue from patient charges. This expansion in our research and training programs will continue to keep New York State's Department of Mental Hygiene in the position of leadership in these fields."

A bill to redesignate the state schools as "State School and Hospital" and to indicate their purpose to be for "care and training" was also an administration bill. The governor in his annual message to the legislature said: "Education and training for mentally retarded children is a primary consideration. Every effort must be made to provide the best possible program for these children. A number of legislative advances were made last year. I recommend that each present state school be redesignated as a 'state school and hospital.' This will not only be more accurate, but will help to solve the difficult problem of recruitment of doctors and nurses for these institutions."

A bill to amend Chapter 191 of the Laws of 1956 creating the Interdepartmental Health Resources Board to add the Chairman of the Youth Commission to its composition was not passed. A bill to amend Section 454 and 662-b of the Code of Criminal Procedure was intended to provide for periodic review of old criminal order commitments and to permit dismissal of indictments so that nonresidents and aliens in these categories could be removed from our institutions—as well as to permit more uniform care and treatment of these persons. It was passed by the legislature; but, when it was sent to the governor, some very strong protests were made against certain of its provisions, and the governor asked the legislature for its recall. This bill and the other three defeated bills just discussed will be introduced at the 1958 session of the legislature as part of the department's program either in the same forms or in slightly modified forms to meet objections.

A bill sponsored by the department to repeal Section 3-a of the Mental Hygiene Law, was added by the 1956 Legislature without the department's full approval, and calling for the transfer of its provisions regarding the Consultant on Aging in the department to Section 7 and the transfer of the provisions involving more than one department to the law organizing the Interdepartmental Health Resources Board, was also defeated.

There were the usual number of bills proposed by groups and persons to amend the Mental Hygiene Law or laws having a direct effect upon the department which were defeated at the request of the department.

Resolutions

Senate Resolution No. 97 continues the joint legislative committee to study the scope of mental retardation. This was created by a resolution adopted April 1, 1955.

There were several resolutions proposed which would have directly affected the department, but they were not adopted.

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"IC.....IC"

Things psychoanalytic
must be esoteric
to be teleologic
or at least climacteric.

If they aren't heuristic
they should be periphrastic
to remain amphilogic
and avoid being spastic;

For we can't be kinetic
on a couch that's harmonic
for anal, oral or erotic

Constellations of neurotics
whose emotions are diuretic
and whose bowels are thrombotic

—A. S.

FOOTNOTE FOR CAVILERS. Readers, if there be any such, whom line 7 has sent to the dictionary, are hereby informed that caviling about the scansion will be a waste of time. Melander (in: *Biological Terms*, Comet Press, New York, 1940) states (p. 43): "Dictionaries often accede to public opinion, accept careless usage... and recognize colloquial mispronunciations... as a choice." He states that compound Greek words are properly pronounced by accenting the "pertinent syllable of the second word." Thus, we make it "am-phi-loj-'ik," from "*αμφι*" and "*λογος*," which scans as acceptable *koine* of the realm, even if not the very best Byzantine. To which one can only add that we say logic is logic—and so to heck with it!

—A. S.

EDITORIAL COMMENT

NOT SIMIAN, NOR SERAPH

The occasion comes, now and again, for a few carefully-selected remarks on honey and luminosity, general do-gooding, spiritual uplift, and the perfectibility of the human race. As psychiatry sees man, he is a creature of many facets. The medical specialist of the mind views him through his own glass darkly as an ill-adjusted, mayhap ill-begotten, subject of delusions, hallucinations and paranoid trends. Under the jeweler's microscope of the scientific cynic, man is no flawless diamond, though he may sparkle like one in a good light. He is nearer to the gem one cuts from a fragment of glass—the polish hopelessly imperfect and the reflecting surface with ineradicable specks and spots in it.

But the scientific cynic's is no three-dimensional view of man. It is not even a reasonably good two-dimensional likeness; it is stiffer than a century-old daguerreotype and no better a representation of the original. It will not even suit the purpose of the psychiatrist—limited as his own strictly professional view must be, for he cannot approach therapy with cynicism, with a hopeless view of man's flaws. To approach effective therapy at all, he must have a wider view than one bounded rigidly by sign and symptom of imperfection; he must attempt to see man as a whole, the healthy man as well as the ill, the potential man as well as the imperfect realization, the man of capacity as well as of incompetence. Such a view of man is scientific, though not cynical; the non-cynical scientist sees the flaws under the microscope; but he sees the shining areas also. If—besides being a non-cynical scientist—he is a social scientist, as psychiatrists are, he also sees man and his imperfections as the subject-matter of his science. For it is the hope and the purpose of psychiatry to do something, however little, about some of man's flaws.

This journal has held forth before on some of the countless ways in which one may view the human race. Man, it has been remarked, is the cooking animal, the talking animal, the mathematical animal. He was recently discussed in these pages as the suicidal animal.*

*Editorial: The suicidal animal. PSYCHIAT. QUART., 31:4, 763-778, October 1957.

The present purpose is to discuss him as what might be called the self-improving animal.

This discussion is inspired by the cynical scientists and the cynical pseudo-scientists who can see nothing ahead but disaster for mankind. In the light of some tens of millions of circling galaxies, the conclusion seems doubtfully justifiable and probably unimportant. If there is other comparably intelligent life in our galaxy—let alone in the hundreds of millions of others we can see with our telescopes—we may possibly relate to it somewhat as pond algae relate to us. Or we may compare reasonably favorably with it—human intelligence making a fair match with approximately equal non-human intelligence. If we live in a big-boom-and-explode universe, as most astronomers seem to think, life everywhere in the cosmos may have started at about the same time and evolved at about the same rate. If we live in a steady state universe of continuous creation, as Fred Hoyle and his school contend, there may be islands of intelligence of millions of years longer development than ours, and other islands far behind human achievement.

We cannot assess the performance of man fairly against any such unknown and speculative background. We must judge—or we should judge—against a much narrower and far better illumined screen. That is the screen of our biological and natural history, human and pre-human. In all conscience, even this screen is dark enough and the figures on it shadowy and elusive enough; it is illumined only in the sense that we can see it at all. The wider background that we cannot see at all—extraterrestrial life and extrahuman intelligence—can relate only to the probabilities that a cosmos-wide life force seems unlikely to be completely self-destructive, and that, in relation to such a force, human self-concern can be vastly exaggerated. If we are part of a cosmic life-stream, the cosmic force which created us may be strong enough to maintain us; in any case, we may expect the cosmic river to keep rolling along.

But cosmos-wide life streams are nearer to being creatures of philosophy—or metaphysics or even religion—than of the science with which we must deal. Human life and intelligence are the present high points on the curve of the only life we can study—that between earthly limits. They have come a long way from the primeval slime. When the scientist, or pseudo-scientist, ven-

tures to say or think that they have come just about as far as they are coming, he is not doing so on the basis of galactic comparisons. But he is, one may suspect, doing so on a basis that is no more realistic.

When the human intellect emerged from animal intelligence, the faculty we know as the ego emerged as part of it, perhaps as the greatest part of it. And the ego promptly set aside parts of itself to create the ego ideal and the super-ego. It is by the standard of the ego ideal, what man wants to be and thinks he ought to be, that man has failed so lamentably. And it is by the standard of the super-ego that he anticipates punishment, suffering, perhaps annihilation, for his shortcomings.

But man himself set up the standards by which he judges himself to have failed. The ego ideal is the child's view of the infallible, omnipotent parent; the super-ego is—with apologies for oversimplification—the internalization of the powerful parents' punishment for failure to obey—to become toilet-trained, to absorb centuries of conformity to culture by the age of three or four.

That the ego ideal and the super-ego also correspond to man's belief in an all-powerful god who exacts retribution for human shortcomings is a different facet of man's character. It is a matter for theology, for man's private and public worship, for the workings of his private and public consciences; and these things are not the subjects of discussion or judgment here. They are matters of right and wrong, as determined by a different set of standards than the scientific. Whether man should be redeemed or damned is the business of the clergy. What man has achieved, in what direction he is heading, what his future on earth or in the bounds of the cosmos seems likely to be are the business of different people altogether. They are the business of the scientist, specifically of the social scientist; and they are of particular concern —within social science—to the psychiatrist, whose study is the emotional ills of the individual and of the society he has created.

By the standards of the ego ideal, man—the whole human race —is a nauseating mess. He is selfish, short-sighted, fearful. He condones poverty and suffering. He tolerates ignorance and superstition. He violates the human worth of social and racial minorities. By whatever theories one measures, his sex life lacks control and dignity. He is immoral personally and publicly. He enjoys inflicting and undergoing suffering. With surplus food here, he

permits starvation there. With medical knowledge here, he allows the curably ill to die there. Above all, he engages in savage and senseless wars, sparing neither the helpless aged nor the helpless infant. And for other of his disgusting habits, see the Hebrew prophets!

Man's actual accomplishments and actual prospects get inextricably tangled with the demands of his ego ideal; and whatever these actual accomplishments and prospects may be, they will never satisfy his super-ego. Let his good works actually outdo his ideals, and there still will be his super-ego to bedevil him. There is good scientific doctrine, as well as good poetry, in Robert Browning's contention that a man's reach should exceed his grasp; his reach always has; and, as far as science can see, it always will.

Before the days of modern psychology, it was generally observed that, in middle age, man underwent a period of "disillusionment." The hopeful young fellow discovered that the world was not his oyster. The youth, spurred by super-ego demands to accomplish the impossible, discovered that very few men could be famous statesmen, world-conquering generals, or literary immortals. The boy brought up on Horatio Alger grew up to find that honesty and industry did not always lead to riches, and that virtue, very literally, was its own reward and a not too satisfying one. In the imperfect world of actuality, the wicked might still flourish, as of old, "like the green bay tree." The incompetent might rise to power, the cheat become wealthy, the drunken he-prostitute attain social or political eminence.

Man's failure to attain his ideals is, of course, inherent in the nature of man, not an artifact of his society. Russia's "classless" society, with its abolition of the "profit-motive," sees both tyrannous and incompetent leaders in power; new "classes" formed to replace the old; new ways of acquiring the luxuries of wealth without private enterprise; new and crueler ways for those who have, to hold in check those who have not. One may suspect that it has been unexpressed but keen insight into the certainty of this kind of thing—unconscious realization of the way man behaves, rather than selfish adherence to private property and private profits—which has made the free world so notably skeptical of Communist paradises. The Communist paradise is so organized that man's shortcomings are certain to cause more tyranny and more suffering than can be inflicted by the wealthy and powerful

in free society. And only a few years ago, Fascist and Nazi totalitarianism worked out an even better adaptation than has Communism, for the purpose of bringing man's less desirable qualities forward and increasing his opportunities for aggressive cruelties.

Both dead Naziism and live Communism illustrate the need of constant vigil if we are to keep certain aspects of human nature under control. But the fact that there are aspects of human nature which should be kept under control is hardly warrant for despair over human nature as a whole. And failure of man to attain impossible ideals is hardly warrant for belief that humanity is a failure as a whole.

Questions of organization, hierarchy or social precedence or political eminence are involved here. Everybody concerned with psychiatry, for instance, has met the young psychiatrist, or the young staff nurse, or the young psychologist, who is justifiably critical of his administrative or professional superior. The clinical director, says the young doctor, should at least listen when a junior ventures an opinion, for how can the junior learn if he does not offer opinions? The administrator, he says, should not be so blunt and arbitrary; he should be able to give an order without implying that his subordinates are intellectually and socially inferior. Or the administrator should be more forthright, even at the risk of being arbitrary; he should be able to reach decisions and to hold to them firmly—not simply listen to argument and then temporize.

If, says the young staff member, the clinical director cannot teach, as well as diagnose, he should not be a clinical director. If the administrator cannot do a perfect job of administration, he should resign as an administrator. Or, listen to the student nurse who realizes she has earned a rebuke from her school head, but thinks she should be rebuked like a lady—or to the clinical psychologist who complains that he is asked to make a differential evaluation and that the psychiatrist then refuses to take account of it.

One can step outside the psychiatric field and find innumerable examples. If the mayor or the governor or the president keeps losing his temper, why doesn't he resign and let somebody who can keep cool take over the office? If the sales manager can't deal with people, why not promote a salesman who can? If the

corporation president's specialities are blondes, champagne and losing money, he should turn the job over to a specialist in hard work, abstemiousness and making money.

Make no mistakes; the complainants, or at least the majority of complainants, are not paranoid. The complaints are justified. Or, at least, the psychiatric, political and business woods are full of tyrannical or negligent administrators, hot-headed officials, poor personnel managers and lazy and improvident corporation executives. But the justification for these complaints is on idealistic, not realistic, grounds. The administrative and professional superiors who harry the young psychiatrist are not ideal characters for their jobs. The one lacks patience; the next decisiveness; the next, professional courtesy. But they are average good human specimens, equipped—in the civil service at least—with enough more than average energy and ability to qualify them, by rigid examination requirements, for the important positions they hold. The bad-tempered elected official has enough qualities of leadership to impress his cynical party leaders and a majority of the electorate. The poor sales manager holds his job because somebody mistook ability to keep perfect books for ability to handle people. The lazy corporation president was an energetic fellow once; his present troubles are caused by arteriosclerosis and lack of incentive to work—now that he has money enough to live comfortably without working.

All these less-than-perfect people are where they are because this is a less-than-perfect world. Man's private reach exceeds his grasp; he can never attain his highest ideals personally; yet he acts aggrieved when society fails to attain them publicly.

When the critical young psychiatrist is older, he will be less ready to demand that the superior who acts improperly or fails to act properly step down and let somebody do the job who can. He will, one hopes, be no less critical; but he will, one hopes, have learned with years that all timber is not clear pine. He will accept joists and scantlings and plates with knots—and realize that most human lumber is knotty, and that the builder does well to find pieces sound enough to serve in spite of imperfections. The young-man-grown-older will not be happy about it, but he will appreciate the problem of construction better than he now does. He may appreciate also that his own personality difficulties (his own neuroses or prejudices or irrationalities) may keep him him-

self from being the ideal administrator when his own time to do the job arrives.

A sermon like this can be rattled off glibly enough to the individual—who is certain to appreciate it in time. But how bring the same truth home to a world-wide congregation—to humanity at large? Perhaps the best way is to view, not the vastly long road ahead, but the vastly long road over which we have already come. When the controversy over evolution was at its height, it used to be disputed whether man was closer to the ape or to the angel. As one may clearly see from his discontent with the less-than-perfect role, he is a long way from attaining the role of angel. But it may be respectfully submitted that he is a still longer way from his simian relatives. Man may be no more monogamous than the ape (Westermarck's monogamous and moral apes now seem to have existed chiefly in the monogamous and moral imaginations of monogamous and moral Victorian missionaries); but the ape, modern research indicates, manages his polygamy as a very brutal fellow. He possesses as many females as he can collect; the females willingly co-operate in his promiscuity, and willingly accept other males in their turn. The old man ape maims or murders such other males ruthlessly, until he is maimed or murdered in time by some younger and stronger, and equally ruthless, specimen with a yen for the old man's females. For the human this kind of once customary conduct is a thing long past—in most of man's cultures.

Man is almost as far removed from the even more unpleasing habits of primitive man. Western man gave up cannibalism for food ages ago, though ritual cannibalism probably persisted much longer—and in other areas of the world, both practices were retained long after they were abandoned by Europeans. Western man, or his physical or spiritual ancestors, has had a culture that could be described as civilized (or nearly so) for four or five thousand years. During the last four or five thousand, he has developed law to protect life and liberty and has given up sacrificing human beings to his gods—though he has been more callous about human sacrifice to his machines or his profit, or his convenience.

Western, modern man—with trivial exceptions—has progressed beyond what used to be the unpleasant general custom of physical mutilation to appease the deity, to appease the unknown, or to

mark acceptance into adult society. Western, modern man in general has given up the habit of massacring war prisoners and the enemy's women and children—though we do occasionally torpedo noncombatants without warning or atom-bomb them. Western, modern man has pretty well done away with exploitation of one sex by the other. The modern wife and her brothers cannot treat the modern husband as a temporary and not too-welcome guest, to be admitted or kicked out as suits biological and social convenience; and the modern man can no longer treat his wife as a piece of property—or even as a domestic animal that he doesn't like very much—whenever there is profit to be made or sadism to be gratified by either performance.

One may wonder if disgust at lack of perfection and refusal to see man's most astonishing progress cannot both be charged in part to modern uncritical acceptance of determinism. When science finally disposed of the legend that man had fallen from grace and perfection, it left human cussedness insufficiently accounted for. Determinism is a convenient way to account for it. If man's behavior is mechanistically determined, like a chemical reaction or a plant shoot's phototropism, man is then what he was made to be, and there is no use worrying about him or trying to improve him. Whether this conclusion is sound philosophically will not be disputed here; it simply doesn't make sense practically.

Whatever the actual determinants may be, we know that—for a random example—man in America has improved himself immeasurably in general capacity for living in the last century or so, by the process of "universal" free education; and the motivation appears to be that he wanted to do so, not that he was compelled to do so. Man in our society has what appears to be choice —if limited—in all manner of situations: whether or not to eat the apple; whether to become an artist or a mechanic or an enlisted soldier; whether to marry the blonde, the brunette or the redhead, or maybe "live in sin"; whether to attend church and seek salvation, or go fishing and let the afterlife take care of itself.

Theoretically, determinism in human affairs may be scientifically sound; practically, it is not scientifically sound (for one test of an idea's scientific soundness is whether it works). There has been more than one human society in which determinism, or fatalism, or belief in predestined behavior was the ruling philosophy;

but such societies have always had the alternatives of stagnation or of making progress by disregarding their professed beliefs. Classic Greece and medieval Islam rose to the heights because men took a grip on their own destinies, scorning the determinism of the Fates and will of Allah. The modern Calvinist accepted his predestination as a doctrine but never let it affect his actions. In each instance, the assumption works that man can choose; and it advances progress; the contrary assumption—however sound it may appear—does neither.

Because this journal has discussed before the frequently deleterious effects of oral and anal reaction formations on our society, it should be remarked with some emphasis that a reaction formation is not Fate and is not the Will of Allah. Something in the way of sublimation and something in the way of education can be done when a reaction formation hampers a free society. The operative word here is "hampers." For instance, great numbers of Americans are certainly too preoccupied for their own good with the Hollywood breast cult; and many more suffer from reactions that come from less than ideal sublimation of anal erotism.* But the victims of these complexes are seldom deprived of freedom of choice, though they may suffer strain, or even show impaired judgment, in exercising it. Yet what appears to be choice is still there. For all but the seriously deranged, personality organization may hamper, but does not foreclose, it.

If man has progressed through choice, it may be worth examining what he has chosen to do—with a view toward what he may choose in the future. Among other things, he apparently has chosen to set up family organizations and societies, to co-operate with other men rather than exterminate them, and to improve means of communication, general technology and the general comforts of life. It may be crediting too much to see these things as conscious, free choices for betterment; but it would be crediting too little to overlook that they were choices—even if forced choices.

Perhaps psychiatrists have been talking too much with their large mouths about the unconscious, about unconscious motivations, reactions and determinants, and too little about the con-

*Editorial: "....It broke the baby's teeth." PSYCHIAT. QUART., 30:1, 131-146, January 1956.

Editorial: In laude Latrinae! PSYCHIAT. QUART. SUPPL., Part 1:129-156, 1957.

scious. It is the conscious after all, the ego if one prefers, that distinguishes man from his animal cousins. The conscious ego may be a small part of the great untamed human mind, but it is the distinctively human part. It is, with reservations, the part to which man owes his progress and his hope. It is somewhat ludicrous to imagine the feeble ego of the ape man of Java pulling itself up by its nonexistent bootstraps—but something like that must have happened when man began to organize his society, his mind and his technology.

The ape man's feeble ego gained strength through the millennia as man learned to communicate by gesture and word. It gained as he learned to chip flint knives, make fire, hunt with boomerang, spear-thrower and bow, plant the first seeds of agriculture, domesticate the dog and cat, tame the horse, cow and pig—and shape wood, wattle and the first mud bricks for his shelter. There was an immeasurable gain when man invented writing to make the experience of egos of the past available for egos of the present and the future. There was another with the slow conquest of superstition and the development of the scientific method and modern technology.

Human intelligence can be defined in almost infinite ways and can be the subject of almost infinite argument. One characteristic is that it seeks to control the environment. Another important distinction between human intelligence and that of the elephant or the bumblebee is that human intelligence seeks to know the "why" of things, the relationships between phenomena, the connection between apparent cause and apparent effect. There are certain matters which no intelligence limited by the confines of the cosmos seems likely ever to comprehend—the ultimate cause, for one thing, or the ultimate nature of the quanta that we experience now as energy and see now as matter. But this side of such questions, man has not done so badly.

If, some day, human intelligence encounters non-human intelligence the other side of Polaris, there is little likelihood that man will have to feel ashamed of himself. From primeval slime in a billion years or so, from the Javanese jungle to mud-brick Sumeria in half a million, and from the first cities to modern science in 5,000 are steps in no trivial achievement. The scientist can be pardoned if he is slightly nauseated by those who wail that we

are not yet perfect and that man is not improvable, while ignoring the enormous progress we have already made.

Observations to this effect have been made often enough before, and have been made in this journal before. But they are the sort of observations that not only bear repeating but demand repeating whenever the Jeremiah-chorus of disaster swells. Proper pride in human accomplishment is the best shield we can raise against the onslaught of despair over the human future.

It is true that our technology now jeopardizes all our achievement—true that we have perfected weapons which we could use foolishly to wipe all higher life from the earth and leave the evolutionary process to start all over again—if there remains any life whatever. Or we could merely wipe most of man from the earth and leave a perhaps primitive minority to start the process of merely creating civilization over again. No thoughtful person can fail to see these things as disheartening and discouraging possibilities. But they are only possibilities.

The threat to civilized man exists because man's ego has not yet attained the perfection of man's ego ideal. There are only two steps man can take—first to see that the threatened horror is not unloosed, second to work toward the closing of the gap between achievement and aspiration, ego and ego ideal. It is a wide gap and will take considerable closing. But man is improvable; he has already improved; and the gap is nowhere near so wide as that between our beginnings and our accomplishments. To return to the old terms of the evolution controversy, man is not yet an angel; but he is a long way removed from the ape.

BOOK REVIEWS

Scientific Method in Psychology. By CLARENCE BROWN and EDWIN GHISELLI. 368 pages. Cloth. McGraw-Hill. New York. 1955. Price $6.00.

Of particular interest in this book on methodology, is the author's attempt to bring basic scientific concepts and procedures to practical demonstration by applying them to typical problems of psychological research. Usually discussions of "scientific methodology" remain on a highly abstract and generalized plane, quite removed from the level of data or observation. This, at times, results in considerable perplexity for the undergraduate student, who finds it difficult, if not impossible, to translate rarified principles into guiding rules, immediately applicable to the research problem before him. Here, the authors, after discussing general underlying methodological principles, proceed to outline explicitly and in some detail, precisely how one may most fruitfully analyze a problem, formulate hypotheses, frame a suitable experimental test of the hypotheses, gather the necessary data, and arrive at proper conclusions. Furthermore, they analyze at some length the nature of the experimental variables which must be isolated, controlled, or in some fashion recognized, and the techniques by which this may be achieved. Various schemes for quantifying behavior are fully reviewed with a brief, but minimally adequate discussion of their respective merits and faults. The weakest part of the book is the presentation of "general concepts about the scientific method." Here, one feels, a more intimate acquaintance with the philosophy of science might have reduced the verbiage, and clarified the basic issues.

The Retarded Child in the Community. By KATHERINE G. ECOB. 22 pages. Paper. State Charities Aid Association. 105 East 22d Street, New York 10, N. Y. 1955. Price 35 cents.

"The Retarded Child In The Community" gives in capsule form a good deal of general information on retardation, stressing the importance of the parental role in the adjustment of the retarded child to his environment. It points out that the needs of such a child differ more in degree than in kind from those of the average youngster.

The general suggestions given for training are only guideposts, however. Broad statements about accepting the child's limitations, helping the child to gain satisfactions, training the child to be an acceptable social being are important, but for many parents, are too vague and nebulous.

The value of routines and consistent patterns of living is stressed: "Since there is little to expect from reason, parents have to rely heavily on an invariable regimen."

English Eccentrics. By DAME EDITH SITWELL. 376 pages including index. Cloth. Vanguard. New York. 1957. Price $5.00.

"It takes all kinds to make a world." No one would doubt the truth of this statement after reading this book. It makes one pause to wonder if there are as many eccentrics in our day as in the periods the author covers. If not, is it because of intolerance, or has the cult of conformity triumphed? Or is it that eccentrics are only recognized in retrospect? In any case, the eccentric is a necessity even though he may be like a burr in the clothing of society. By being different, he makes the conformists examine their position, if not change it. By being different, he often sees facets of the truth that the conformist with his blinkers is unable to see. Even if he adds nothing to our knowledge, he is stimulating and provocative, and often, irritating.

Carlyle, Ben Johnson, Spencer De Quincey and other less known eccentrics receive their due from the pen of Edith Sitwell. Needless to say, she does not detract from their color but rather adds to it by her pleasant, vivacious and witty style.

Progress Against Prejudice. By ROBERT ROOT. 165 pages. Cloth. Friendship Press. New York. 1957. Price $2.50.

A Syracuse University professor examines the nation-wide struggle against prejudice in the wake of the Supreme Court's desegregation decision. He has compiled incidents to bolster his contention that racial prejudice is slowly but inevitably being rolled aside. As an optimistic realist, he has devoted part of his book to a recitation of situations when prejudice continued to rule, and enlightened tolerance was repulsed. His particular target in this book is integration of the races in religious worship. He charges that the church is one of the most segregated areas, and that more progress has been shown in decent employment and housing for Negroes than in the field of religion. Even here, however, he points to numerous acts of the highest idealism, and this book gives a spiritual lift to those who believe in equal opportunities for all.

The Luciano Story. By SID FEDER and JOACHIM JOESTEN. 327 pages. Cloth. McKay. New York. 1954. Price $3.75.

This is a dull recounting of the life of Lucky Luciano. The book tells of Luciano's connection with organized crime but does not delve into the psychology behind it in any way. It is overcrowded with names and leaves many questions unanswered, among which perhaps the most important is, "How can a man who has led a life of crime for over 40 years, go—with one exception—unpunished?" The one bright point in the book is the description of Luciano's work in counter espionage during the war, while he was in prison. But this point too, while interesting, is very cloudy as to methods.

The Doctor as a Witness. By JOHN EVARTS TRACY. 221 pages including index. Cloth. Saunders. Philadelphia. 1957. Price $4.25.

For any doctor who must appear in court as a medical witness, this book has much to offer. Much embarrassment and harassment would be saved if this book was studied prior to appearance in court. (When the doctor appears as a witness, he is to some extent representing the medical profession. It behooves him to act with dignity, modesty and intelligence.) Included in the book are chapters on direct examination, cross-examination, and discussion of testimony where insanity, workmen's compensation or malpractice is the issue. There are useful hints on preparation for the trial and on the qualifications of a good medical witness.

Language and Society. By JOSEPH BRAM. 66 pages. Paper. Doubleday. New York. 1955. Price 95 cents.

Approaching the topic from the framework of anthropology and sociology, Dr. Bram presents an excellent outline of current knowledge of the role of language in the socialization of the individual and maintenance of social organization. The factors contributing to the resistance or susceptibility of language to change are traced. Of particular interest, is the discussion of the relationship of language to naturalistic feeling, to social conflict, and to the destruction of social power. Various "sciences of language" are described. This is altogether an admirable introductory exposition.

Becoming a Mother. By THEODORE R. SEIDMAN, M.D. with MARVIN H. ALBERT. 264 pages including index. Cloth. McKay. New York. 1956. Price $3.50.

This book provides an excellent source of facts for the uninformed woman and an equally good reference source for others. It emphasizes throughout that the material compiled is only a general guide and that all problems should be handled as individual ones by the patient and her physician. It discusses pertinent problems from the time of menstruation through pregnancy, delivery, and care of the baby, and includes an excellent chapter on how and what to prepare for baby. The author has managed to make this book very pleasant reading and in spots humorous as well.

Psychological First Aid in Community Disasters. 32 pages. Paper. American Psychiatric Association. Washington. 1954. Price 35 cents.

This manual was published at the request of the United States Federal Civil Defense Administration. It gives a rationale for psychological first aid, describes the various reactions to disaster conditions, explains the principles used to help the emotionally disturbed and gives practical suggestions.

Alcoholism. By RUTH FOX and PETER LYON. 194 pages. Cloth. Random House. New York. 1955. Price $3.00.

It is regrettable that a specialist on alcoholism, confronted with the unfamiliar task of writing a popular book on her favorite topic, has nothing important to say. The facts that alcoholism is a neurosis, and psychotherapy is indicated, are not exactly news. The explanations of dynamics are in this reviewer's opinion, out of date; and therapeutically, an unjustified and rather sterile pessimism prevails. The blame is finally shifted to society: "The goal we should aim for is a society in which there will be more of us sufficiently free of tension, sufficiently capable of amity and love for our fellows, that drugs will be confined to the medicine shelf." Hopes for the future do not alleviate individual psychopathology.

Collectivism on the Campus. By E. M. ROOT. 383 pages. Cloth. Devin-Adair. New York. 1955. Price $5.00.

An important book proves with documentary evidence the Communistic infiltration in many schools and colleges. The author warns against underestimation of these small groups, because of their great potential influence, even after their main "leaders" are removed: "Certain insects lay their eggs in the living flesh of other insects: their larvae, hatching within the hosts, feed on them till they kill them, then break forth to live their own lives. So Communists function in the academic world."

Deciding What's Best for Your Retarded Child. By KATHERINE E. ECOB. 14 pages. Paper. State Charities Aid Association. 105 East 22d Street. New York. 1955. Price 35 cents.

"Deciding what is best for your retarded child" is a complex and difficult problem for a parent. The usefulness of this pamphlet to the parent lies in its simple, orderly presentation with a text that is clear and free from professional terminology. It takes only a few minutes to read but it is packed with practical material and is to be recommended highly.

Social Organization. By SCOTT A. GREER. 68 pages. Paper. Doubleday. New York. 1955. Price 95 cents.

The clinician is interested in the understanding and prediction of individual behavior. Too often, there is insufficient recognition of the important influence of "social role," or "status" in determining a patient's everyday behavior. In the present small volume, Professor Greer provides helpful assistance for the study of "behavior which is motivated and constrained by the necessities of cooperation as these emerge in human groups." The clinician should find the discussion both interesting and useful.

Basic Psychology. A Study of the Modern Healthy Mind. By LEONARD CARMICHAEL. 340 pages. Cloth. Random House. New York. 1957. Price $3.95.

Dr. Leonard Carmichael, one of America's foremost psychologists, is the author of a distinctly sound approach to psychological thinking in *Basic Psychology: A Study of the Modern Healthy Mind.* Now serving as secretary of the historic Smithsonian Institution, the author also shows clearly his deep understanding of physiological psychology. But more: He is also a humanist in psychology, concerned with areas of fatigue and human efficiency, the relatedness of man and woman in our contemporary world, the human brain and the human mind, man's conscious experiences in living, the roles of memory, habit, emotion, and the biological urges and drives in our lives.

Dr. Carmichael writes with authority and simplicity in clarifying accurately some of the enigmas of human behavior. He examines, with insight and factually, the structures, functions, motivations and manifestations of the modern healthy mind. His chapters on personality, intelligence, emotions, and the human mind are excellent; and *Basic Psychology* argues for the use of psychology as an adaptive social science.

Essentially this book is a non-technical introduction to the psychology of the normal, adult, civilized person of our time. To the author, scientific psychology deals fundamentally with the interaction between a living organism and the world in which that organism exists; and the theme throughout this volume is that psychology has as its forte the consideration of the aspects of the kind of mental life that give man at his best a unique place in all creation, and his dignity as a free individual in an achieving society. *Basic Psychology,* then, is recommended highly to all social scientists and intelligent laymen for clarifying the vast and growing scientific literature and laboratory experimentation about the principles and processes of human behavior.

City Limits. By NICK MARINO. 160 pages. Paper. Pyramid Books. New York. 1958. Price 35 cents.

It was unavoidable in the detective "literature" that Mike Spillane's tough detective should find a counterpart in the slugging district attorney. That's the new idea in the present volume: lack of psychological motivations is compensated for by beating and bullets. There is irony in the publisher's announcement: "Nick Marino [the author] is a pen name hiding the identity of a top-ranking author who has scored many outstanding literary successes." This reviewer thinks he has every reason to hide.

Psychoanalysis: Evolution and Development. By CLARA THOMPSON, M.D. with the collaboration of PATRICK MULLAHY. 252 pages including index. Paper. Grove Press. New York. 1957. Price $1.45.

This is a paper-backed reprint of an excellent survey of the psychoanalytic movement and its divergent schools, written by an adherent of the Washington group. The author's point of view is set forth clearly by Dr. Thompson, who notes that she has tried to be objective but is human, and that her background, therefore, should be made known to the reader. The survey, like other neo-Freudian studies, has been criticized by the orthodox as somewhat patronizing toward Freud, and his generally conforming followers. It also certainly does overemphasize the roles of Sullivan, Ferenczi and Fromm. It is nevertheless one of the clearest and most readable statements covering the development of the psychoanalytic movement from its beginning to the mid-twentieth century, of which this reviewer knows. It is to be recommended for the library of any student who can keep the orientation of its author clearly in mind.

Directory of American Psychological Services. 1957. American Board for Psychological Services, Inc. 156 pages and index. Paper. Distributed by American Board for Psychological Services, 9827 Clayton Road, St. Louis, Mo. Price $1.00.

This directory is a listing of psychological services, agencies and individuals who are equipped to give advice or help in various psychological fields. Included, are schools for exceptional children with therapeutic methods noted, consultation services for children, and vocational educational testing services. Universities, public services, corporations and individuals are indexed. The arrangement of the book is by states and the two Canadian provinces of Ontario and Quebec. The American Board for Psychological Services, Inc. notes that the listing is voluntary and that failure to be included "does not and cannot" be taken to mean lack of qualifications.

This directory should be useful to any institution or individual having occasion to refer persons for any sort of psychological services.

Passport To Friendship. By WILLIAM PETERS. 286 pages. Cloth. Lippincott. Philadelphia. 1957. Price $3.75.

This book displays an amount of naïveté which borders on the ludicrous. It describes experiences of American exchange "students" in foreign countries. There is no objection to such visits to other countries, but to include Nazis among those visited goes a little far—especially if the idea is maintained that human solidarity can be thus furthered. The result of the Nazi experiment is that the visitor overlooks the real problem.

Risk and Gambling. The Study of Subjective Probability. By JOHN COHEN and MARK HANSEL. 153 pages, including index. Cloth. Philosophical Library. New York. 1956. Price $3.50.

This book is a first attempt toward an experimental and scientific approach to the study of subjective probability. Proceeding on the assumption that people in general regard events as dependent on previous outcomes rather than as independent phenomena, the authors proceed, through specially designed experiments involving children and adults, to investigate the subjective beliefs in chance, luck, and magic that influence ideas of risk or probability.

Topics such as risk taking, guessing or estimating, gambling, and certainty and doubt are explored and discussed from a developmental standpoint. Since so much of our private and social behavior in everyday living is covered by risk taking, this book should be of interest to the general reader as well as to the professional psychologist and educator. It does not explore the psychodynamics of the gambler.

The Abnormal Personality. By ROBERT W. WHITE, Ph.D. IX and 644 pages including name and subject index. Cloth. Ronald. New York. 1956. Price $6.50.

This is an excellent basic book for the student of abnormal psychology. It covers the entire field, including a short history of abnormal psychology, development of the personality, the neuroses, character disorders and the functional and organic psychoses.

The chapter on schizophrenia is exceptionally well presented although frankly biased in favor of the psychogenic etiology and approach. It also follows the trend of de-emphasizing the secondary symptoms of schizophrenia, although pointing out that these are meaningful and are not to be entirely disregarded.

The Menninger Story. By WALKER WINSLOW. 337 pages. Cloth. Doubleday. New York. 1956. Price $5.00.

This is a friendly, respectful and well-meaning biography of the Menningers, especially of the Grand Old Man, Charles Frederick. The book started with the author's assignment by the *Saturday Evening Post* to do an article on Winter Veterans Administration Hospital, managed by Karl Menninger. The book is on a journalistic level, and avoids any attempts at psychological explanations.

The Philosophy of Psychiatry. By HAROLD PALMER, M.D. X and 70 pages. Cloth. Philosophical Library. New York. 1952. Price $2.75.

This little book attempts to draw together the concepts of philosophy and of psychiatry. Such topics as the "self," "mind," and "thought" are covered.

The Handicapped and Their Rehabilitation. HARRY A. PATTISON, M.D. editor. XXXII and 944 pages. Art leather. Thomas. Springfield, Ill. 1957. Price $14.75.

Rehabilitation of the Handicapped refers not only to those with obvious physical traumata, such as loss of sight, but also to such equally important but less often thought of problems as advanced age and mental illness.

This book is designed as a reference work, rather than a text. The articles cover a very wide range—both in regard to disabilities and to rehabilitation methods. The contributors are authorities in their fields.

The emotional problems connected with rehabilitation are covered well. The section specifically devoted to psychiatry and psychotherapy is by Edward A. Strecker, M.D. His views are essentially non-Freudian, but this reviewer feels that this attitude does not detract from the usefulness of the principles expressed. Rehabilitation of the mentally ill is covered by Jack Meislin, M.D. The emphasis is on the importance of "a dynamic, well integrated, intensive and realistic rehabilitation program at the hospital level." With mental illness, it does little good to remove a hallucination if the patient is unable to face the outside world. "Social recovery," if that is the best result possible, then becomes the objective here.

Naven. Second edition. By GREGORY BATESON. 312 pages. Cloth. Stanford University Press. Stanford, Calif. 1958. Price $6.00.

Naven is a study based on field work among head-hunters in New Guinea and first published in 1936, when the author reviewed this field work in the light of theory. It is now published with a second epilogue, written in 1958, and is of principal value for that reason. Bateson and anthropology have made great advances since the 1930's. This second epilogue is worth the attention of any social scientist; and the subject of it (the original book) is presented in full for study. Cybernetics and progress in psychiatry have played their parts in bringing about the change of views and methods. This book is an excellent example for psychiatrists of the influence of their speciality on an important related discipline.

Alcohol and the Jews. By CHARLES R. SNYDER. 226 pages including index. Cloth. Free Press. Glencoe, Ill. 1958. Price $5.00.

This book is based on a doctoral dissertation, first published in the *Quarterly Journal of Studies on Alcohol*. It is a social and psychological study of drinking patterns among persons of Orthodox, Conservative, Reformed and secular Jewish groups. The study supports the general opinion that there is very little alcoholism among the Orthodox and Conservative Jews, and that, as the Jewish groups approach the cultural average, drinking increases. It is an excellent and useful analysis.

The Ashanti. By ROBERT A. LYSTAD. 212 pages including index. Cloth. Rutgers. New Brunswick, N. J. 1958. Price $5.00.

Ghana is the newest of the family of independent nations now making up the British commonwealth of peoples. Central in the formation of this African state are the Ashanti. This is a report by an American anthropologist of how these negroid people are maintaining and adapting their traditional and ancient institutions to the requirements of a modern world. The Ashanti and the peoples who have joined with them to create Ghana are forest Negroes. Their country is tropical, and their ancestors were active in the slave trade. The uninformed American commonly supposes them to be primitive (practically savage) and totally unfitted to govern themselves. Lystad's report is a refutation of these beliefs and a very interesting one. The Ashanti are adapting a matrilineal polygynous society to modern needs. They are also adapting their occupations, their education, their means of government and their gods. Lystad thinks that there eventually will be some sort of "synthesis of Christianity and paganism, and this, of course, is the most practical and the most likely outcome for religion in Ghana."

The Ashanti is a popular, not a scientific, work but it is difficult to imagine a social scientist who will not be interested in it. Of almost equal interest is the fact that the author who lived among these Negroes is now associate professor of anthropology at Tulane, a matter which must have some significance in the progress of our own South.

The Young Child in School. By CLARK E. MOUSTAKAS, Ph.D. and MINNIE PERRIN BERSON. 256 pages including index. Cloth. Whiteside. New York. 1956. Price $4.00.

This is a very interesting and stimulating book about the education of the nursery school child. At this time, when there are fears that Russian education is possibly better than our own, investigation of our educational system becomes increasingly pertinent. There may be some disagreement about the desirability of nursery schools at all. However, with more and more mothers going to work, many of them by necessity, the need is going to continue.

The authors present a broad picture of nursery schools and four general theories of education and their related practices. They discuss physical health and well-being, social growth, intellectual experiences and the parent-teacher relationship. They believe in an individual approach to the child, with an attempt by the teacher to enlarge the child's capacity to learn and develop rather than to fit every child into the same mold.

William Byrd of Virginia. The London Diary (1717-1721) and Other Writings. LOUIS B. WRIGHT and MARION TINLING, editors. 647 pages, including an account of Byrd's life and an index. Cloth. Oxford. New York. 1958. Price $10.00.

Three and one-half years of the daily life of William Byrd are covered by the diary entries reproduced in this volume. Besides being of great interest to the historian and student of colonial and English social life in the early eighteenth century, they are also worth the close attention of the psychologist. This is because Byrd, like Pepys before him, kept his diary in a shorthand he supposed nobody else could read, and reported his daily life in consequence with notable lack of inhibition. He pays particular attention to recording when he got up, what he had for his meals, what people he met, and what women he went to bed with—there were scores of the latter, and he apparently was not even deterred by gonorrhea. He also notes faithfully whether he said or omitted his prayers, using the same words (apparently as a magic formula to exorcise regrets or guilt) when he fails to pray and when he has casual intercourse in his coach or in a bagnio—"for which God forgive me."

A personality organization with such a complaisant super-ego (and the diary suggests it was typical of the "gentlemen" of his day) is worth the attention of any student of psychodynamics—or of eighteenth-century morality. In the "Other Writings" of the present volume, there is much additional material of wide interest to the social scientist, Byrd's keen and well-reasoned observations, for instance, on the folly of the early colonists in failing to marry extensively with Indian women; and his devastating opinions of the riffraff inhabiting North Carolina—as viewed by a Virginia aristocracy perhaps itself only a generation or two removed from "trade."

Three Wise Virgins. By GLADYS BROOKS. 244 pages. Cloth. Dutton. New York. 1957. Price $4.00.

In these delightful biographical sketches, the author presents us with the story of three unusual nineteenth century New England women, all of them friends of, and influenced by, the great liberal religious leader, William Ellery Channing.

The name of Dorothea Lynde Dix is, of course, a familiar figure to all those interested in the mentally ill and the story of her struggles and accomplishments that is presented here is well worth reading. The portraits of Elizabeth Palmer Peabody, who exerted a great influence on modern education, and of the author, Catherine Maria Sedgwick, are also of considerable interest.

Disorders of Character. Persistent Enuresis, Juvenile Delinquency and Psychopathic Personality. By JOSEPH J. MICHAELS, M.D. 121 pages. Cloth. Thomas. Springfield, Ill. 1955. Price $4.75.

Believing that there was a close association between persistent enuresis, character disorders and personality malintegration, the author has studied these problems over a period of 18 years.

He finds that the incidence of enuresis was significantly higher in the groups with psychopathic personalities, mental deficiency and psychiatric behavior problems. This last group had not only the highest incidence but also the greatest persistence of enuresis past the age of 10 years. These observations would seem to justify the hypothesis that enuresis, in its stubborn persistence, reflects psychosomatically the lack of an internal inhibitory agency, just as delinquency later reflects this lack sociopsychologically . . . There probably is a special kind of psychosomatic disposition revealed in a high degree of irritability, explosiveness, impulsiveness, and uninhibitedness which permeates the whole personality.

"Enuresis, then, is seen as a psychosomatic disorder of bio-psycho-social nature with implications of both a general (biological and phylogenetic) and specific (psychological and ontogenetic) nature, the further study of which should prove most fruitful. Persistent enuresis may be regarded as the bio-psycho-social paradigm for behavior that is characterized by a lack of control due to deficiency in inhibition, a deficiency that bridges the structional-functional (biological) substratum and the psycho-social cultural forces."

Psychiatry and the Bible. By CARROLL A. WISE. 169 pages including index. Cloth. Harper. New York. 1956. Price $3.00.

Psychiatry and the Bible is the work of a minister who has previously written a text on pastoral counseling. In the present book he illustrates —by Biblical incidents and precepts—many problems of psychiatry and much good practice of mental hygiene. In his chapter on "guilt and forgiveness" he says: "The explanation of this tendency to find sin as a cause for all suffering can only be found in the projection of our own feelings of guilt and our own need for punishment onto others. . . . Thoroughly benevolent persons, such as Jesus, have no need to feel hostile to others, since they are free of all such guilt and its resulting hostility and are able to give love and understanding."

The reviewer thinks this book will be of considerable use to chaplains and others concerned with the spiritual welfare of mental patients, and that the clinician whose patients present religious problems may find it useful also.

Triumph Over Odds. J. DONALD ADAMS, editor. 487 pages. Cloth. Duell, Sloan and Pearce. New York. 1957. Price $6.00.

In non-technical language, *Triumph Over Odds* is an anthology of inspirational material dealing with man's indomitable spirit. Many of the articles are classics and a good half of them relate to "Man Against the Inner World," incidents ranging from *Job* to John Gunther's account of the illness and death of his son. The section relating to man against the outer world ranges from the story of David and Goliath and the march of the ten thousand to the climbing of Annapurna and the adventures of the modern speleogists. Included are Herodotus' tale of Thermopylae, Nelson at Trafalgar, Clark's march on Vincennes and Sidney Stewart's story of Bataan.

The incidents of mental trial include the pitiful story of Charles and Mary Lamb, the last years of Dickens, a sketch of Van Gogh, Byrd's ordeal at the South Pole, and Van Wyck Brooks' own story of his mental illness and four years of hospitalization. Scott's account of death in the Antarctic and Arthur D. Divine's story of Dunkirk are other classic incidents. Oddly enough, although there is other World War II material, there is nothing from the experiences of the sufferers in Hitler's concentration camps.

Many readers will gain from this splendid anthology. It deals largely with death—where man's triumph can only consist of courage in facing the inevitable—and so is probably not ideal reading for the depressed; but it can otherwise be recommended unreservedly as good mental hygiene.

An Introduction to Psychology. By HARRY W. KARN and JOSEPH WEITZ. 315 pages with illustrations. Cloth. Wiley. New York. 1955. Price $3.90.

Introductory psychology is one of the most difficult topics to write about. All present texts displease relatively large numbers of psychology instructors, and each year sees attempts to meet the many criticisms.

It would seem that one kind of criticism that the present authors have tried to meet is that current texts are "too technical," "too formal and stylized." Consequently they have adopted an "informal" style, which attempts to speak to the student in a friendly conversational tone, with a minimum of technical vocabulary, involved explanations, and detail. The result, however, is not particularly useful, at least for a university course. The topics are too diluted, are stripped of necessary, though perhaps boring, detail and lack technical sophistication required on the college level. It is to the credit of the authors, though, that they are alert to modern trends in conceptualization, and to recent experimental work. For example, emotion is treated in a motivational framework.

Psychology in Living. Third edition. By WENDELL WHITE. 307 pages. Cloth. Macmillan. New York. 1955. Price $4.50.

The author has included six new chapters in this third edition. Each of these concerns topics in the area of adjustment and personality, such as "love and self-reliance in childhood," "sympathy," and "pleasant and unpleasant motivation." The rest of the book is taken over from the second edition and contains the usual range of topics. Typical of these are the chapters devoted to "love," "courtship," "self-confidence with modesty," "envy and jealousy," "enjoyable work" and the ubiquitous "mental conflict and frustration." Perhaps the most that one can say for such books as these is that they cannot injure intelligent readers; the uninformed may glean some second-hand gem of wisdom from them.

Psychiatric Nursing. By RUTH MATHENEY, R.N., B.S., M.A., and MARY TOPALIS, R.N., B.S., M.A. Second edition. 259 pages. Cloth. Mosby. St. Louis. 1957. Price $3.50.

This is a concise, well-written book which would serve either for a reference work or as a textbook for psychiatric nursing personnel. The authors have placed the emphasis on understanding patients and their behavior patterns rather than on understanding psychiatric nursing per se. Behavior rather than diagnosis has been stressed; and this attitude fits in with the dynamic approach to psychiatric nursing. For those who are concerned with following diagnosis, the appendix contains an excellent condensed A.P.A. classification of mental illness which can easily be followed throughout the text.

Child Guidance. By RICHARD SLOSSON, M.A. Paper. The Office of Health Education. Erie County Health Department. Buffalo. 1957. No charge.

This is a skit designed to bring out certain problems and techniques of child guidance. It also demonstrates the roles of each member of the child guidance clinic staff. This skit, along with a discussion period, would seem to be an excellent way to promote understanding of the uses and goals of the child guidance clinic.

The Dark Arena. By MARIO PUZO. 308 pages. Cloth. Random House. New York. 1955. Price $3.50.

A well-written book deals with a neurotic G.I. who, after the war, could not adapt himself to civilian life, and returned to post-war Germany for a job with the military government during occupation. The hero is an injustice collector, and always angry with people who treat him nicely. Taken as an individual neurotic case, the hero has validity (though he is not explained); the book can, however, be misunderstood by lay readers.

The Nursery School. A Human Relationships Laboratory. Second edition. By KATHERINE H. READ. xi and 297 pages. Cloth. Saunders. Philadelphia. 1955. Price $4.00.

Katherine H. Read, of the School of Home Economics of the Oregon State College, strives, in *The Nursery School,* to express her understanding of human behavior—and succeeds rather well at it, too. To Professor Read the nursery school laboratory contains perhaps most of the ramifications of life's activities, in various and diverse forms, to be sure. The author writes descriptively and authoritatively on how children adjust to new experiences, how they handle routine situations, and how feelings of confidence and adequacy may be built up in children. She discusses the handling of feelings of aggressiveness and hostility, and discourses generally on how children may be taught to express a sense of responsibility. *The Nursery School* is somewhat textbookish in format and is apparently designed for study in the classroom rather than for general reading. But it is a sound presentation, with attractive illustrations, and an abundance of supplementary references, to material of use for adults—teachers and parents—who wish to increase their understanding of children.

Mothers and Sons. By I. COMPTON-BURNETT. 256 pages. Cloth. Messner. New York. 1955. Price $3.50.

In a style supposed to be witty, the author mishandles an important topic turning it into a bathetic comedy of manners ("bathetic" is ludicrous descent from the elevated to the commonplace—Webster). The reviewer thinks any resistance to turning the pages is not the reader's fault: Reading this book is like swimming in a sea of tainted marmalade. The author has 14 books on her list; with one exception, all titles have the word "and" prominently displayed: One cannot but wonder at the meaning of it.

Hospital City. By JOHN STARR. 278 pages. Cloth. Crown. New York. 1957. Price $5.00.

A journalistic book on the history of Bellevue Hospital, New York City, is made up of sketches about prominent physicians. A good deal of material is included, though the job is superficial.

All Men Are Mortal. By SIMONE DE BEAUVOIR. 345 pages. Cloth. World. Cleveland. 1955. Price $5.00.

In her previous books, the Existentialist author proved, this reviewer thinks, to be confused, logorrhoeic, boring. In *All Men Are Mortal,* a new touch is added: unreadability. A French actress meets a man cursed with immortality—he was born in 1279, and is still alive, but in constant danger of falling asleep. The reader may suspect that the author intends to prove some tenet of the Existentialist theory (the book is dedicated to Sartre) but is in the same danger as the hero—that of succumbing to sleep.

Matter, Mind and Man: The Biology of Human Nature. By EDMUND W. SINNOTT, Ph.D. 225 pages. Cloth. Harper. New York. 1957. Price $3.50.

What is man? What is his position in the world and the animal kingdom? Is he solely the product of a group of cells, little more than a machine? Is there a purpose to life which is evident in all living things, and if so, what is that purpose?

These are some of the questions discussed and answered in this scholarly book. True, the answers may not be satisfactory to all readers, but they are provocative and stimulating and may lead the reader to answers of his own.

Sinnott's main hypothesis is that all living things have a self-regulating capacity. "This quality of self-regulation . . . is a uniquely biological phenomenon and an understanding of it, I believe, will provide a clue to the character of life itself." From this hypothesis, the author feels certain inferences can be made. One is that there must be something within the organism to which these self-regulatory activities tend to conform—a goal or a norm. Regulation to this norm then implies purposive actions on the part of the organism. To follow the argument further, mind grows out of that self-regulation and goal seeking. Mind is defined as "Whatever directs the development and activity of an organism towards goals set up within its living stuff." The soul is defined as (and notice this distinction in comparison to the definition of mind): "The highest level of that goal seeking integrating process that is life."

The author makes another distinction: that of the spirit which, if the reviewer's interpretation is correct, is the soul plus other qualities. "It [the spirit] is a moving experience of desires and aspirations carrying an inner certainty of their own high character and with power at times to lift us out of ourselves."

As defined, the spirit seems to be the need or desire for beauty, love, truth, etc. and the satisfaction of these. And the author argues, why is this not comprehensible? Just as lower goals set up in protoplasm can be attained, so can higher goals. If it were otherwise, nature would be inconsistent.

The concept of living things having a self-regulatory or organizing capacity, leads to other inferences. Where does this organizing capacity come from? It also brings up the question of immortality. "If this power comes from something that flows in from the creative reservoir in the Universe . . . then, we may ask why it should not return again to the source from whence it came."

In conclusion, the author writes, "The suggestions here presented are an attempt to provide a few such answers that will form a unified and

logically harmonious framework of conceptions about man and his relations to life and to the Universe. They are anchored in science but reach out far beyond it. Upon this framework, I believe, can be constructed a philosophy that will satisfy many who respect the demands of intelligence, but also recognize values of the spirit—a philosophy that in the best sense of the word, may be called religious."

The Greer Case. By DAVID W. PECK. 209 pages. Cloth. Simon & Schuster. New York. 1955. Price $3.75.

The author, presiding judge of the Appellate Division, State of New York, collected the data of the notorious Greer case, a "sensation" of 1946. A wealthy woman left her half-million dollars to an institution of learning, but, at the time of signing her will, confessed to her lawyer and acquaintances that she had had an illegitimate child—not mentioned in the will. Later, suit was brought without convincing the court. More interesting than the incident itself, is the question of why such cases arouse so much public interest. The reviewer would note voyeurism (without going into questions of deeper motivation) in seeing the sordid details of a woman's past exposed; and revival of infantile repressed fantasies of "noble" birth. Needless to say, the present book does not deal with such problems.

Philosophical Psychology. By J. F. DONCEEL, S. J. 349 pages. Cloth. Sheed & Ward. New York. 1955. Price $4.50.

This book is well written and may have its value in clarifying what is meant by a philosophical psychology. The first half reviews the concepts of psychology in general. The rest presents a philosophy of man based on the Aristotelianism of St. Thomas Aquinas. However, there are no allusions to Thomistic philosophy or to the Catholic doctrine to which the non-Catholic would take exception.

The Hearth and the Strangeness. By N. MARTIN KRAMER. 402 pages. Cloth. Macmillan. New York. 1956. Price $4.50.

This is the first novel of a new writer; the dust jacket merely gives the information that the author's "hobby" is "inventing people and situations." In this reviewer's opinion, he unfortunately omits the invention of credible motivations.

The Mercy of the Court. By MONICA PORTER. 252 pages. Cloth. Norton. New York. 1955. Price $3.50.

A judge who withstands political pressure, and decides a case according to his conscience, despite the certainty of ruining his career, is certainly an admirable figure, but there is insufficient psychological motivation shown to make a novel.

This Life I've Led. By BABE DIDRIKSEN ZAHARIAS. 232 pages. Cloth. Barnes. New York. 1955. Price $4.00.

An autobiography of the golf-champion, as told to Harry Paxton, is the story of a seemingly happy woman, courageous even in dangerous illness. She reveals, however, nothing except the external events of her career.

Therapeutic Education. By GEORGE DEVEREUX, Ph.D. XXVIII and 435 pages. Cloth. Harper. New York. 1956. Price $5.00.

The author, a psychoanalyst, discusses the education of severely disturbed and defective children from both the theoretical and practical aspects—with the emphasis on theory and the contributions it can make to practical applications. The contributions of psychoanalysis to the understanding of mental disturbance are demonstrated, but the author considers "therapeutic education" to be an offshoot of education—not psychoanalysis. It is necessary at times to accept "half a loaf" rather than insist on a "whole loaf." Social and parental resistance can limit the degree of adjustment possible to any child.

Attempting to unearth the theoretical bases for the education of disturbed children leads to many byways—including both psychoanalysis and anthropology. The result is a book that has great potential value, but is not particularly "easy" to read. Therefore, this book has limited applications for classroom teachers; it has many more for clinical psychologists and psychiatrists.

American English. By ALBERT H. MARCKWARDT. 194 pages including index. Cloth. Oxford. New York. 1958. Price $4.50.

Much of the material Marckwardt has collected in this volume can be found in H. L. Mencken's *The American Language* and its supplements. Marckwardt, however, has reduced it to less unwieldly dimensions and has presented it without Mencken's Anglophobia. Any worker with scientific English must note the differences in usage in British publications, others from the British Commonwealth of Nations, and American. This volume, however, does not cover the question of scientific language. It is rather a primer, which can serve as a very useful introduction and guide to the differences between nontechnical standard British English and standard American English. It would be an excellent volume for the shelf of writing tools in any library used by students of science.

The Brat. By GIL BREWER. 144 pages. Paper. Fawcett Publications. Greenwich, Conn. 1957. Price 25 cents.

In this tale of a demoniacal girl from the swamps, who brings destruction to her husband and herself in an attempt to impress a hated family, absurdity is piled on absurdity.

Sick Sick Sick. By JULES FEIFFER. Unpaged. Paper. McGraw-Hill. New York. 1958. Price $1.50.

Jules Feiffer's cartoon characters do not reach the algolagniac depths of Chas. Addams; but they bring an eerie breath of irrationality down the back of the neck just the same. They are cartoons of the neurotics, the psychopaths and the other not wholly rational characters that inhabit Greenwich Village, the summer resort, the office, the bar and almost every place else. There is a masochistic overtone in the sketches of the girl who is stood up on a blind date, the unseducible young lady at the party, and the statesman pleading that we live with nature's law and make the rest of the world respect us for "our moral stand." There is a neat series on the quiz show, where the young lady is questioned about her motivations and the answers are all checked by her analyst. Illustrations for the psychoanalysis of Oedipus—Oedipus Rex in person—might also be mentioned.

This is a collection that no analytically-oriented psychiatrist should miss.

The Atomic Age and Our Biological Future. By H. V. BRØNSTED. 80 pages including index. Cloth. Philosophical Library. New York. 1957. Price $2.75.

This is a short, popular work, written by a competent scientist. It concerns chiefly the possible effects of radiation in our atomic age on the human future. Brønsted thinks that what is more likely than the production of living monstrosities by overdoses of radiation is the production of numerous mutations that are not viable at all. That is, affected humans would not produce monstrosities; they would not produce at all.

The book is a useful introduction for any scientist or non-scientist concerned with the problem.

Riddles of Science. By SIR J. ARTHUR THOMSON. 222 pages. Paper. Premier. New York. 1958. Price 50 cents.

Sir J. Arthur Thomson's work outlines a number of today's scientific questions for the general reader and answers a few of them. The book is of the primer variety and the discussion vastly simplified. It can be recommended as useful to any person with a beginning interest in science, a high school reader or school of nursing student, for instance.

The Three Lives of Naomi Henry. By HENRY BLYTHE. 160 pages. Cloth. Citadel. New York. 1957. Price $3.00.

The Three Lives of Naomi Henry is a British analogue of *The Search for Bridey Murphy*. The author is a stage hypnotist. Both he and his subject appear to be acting in good faith. The "evidence" for reincarnation that they present is to precisely the same effect as in the Bridey Murphy story and leads to exactly the same negative conclusions.

The Loom of History. By HERBERT J. MULLER. 433 pages including index. Cloth. Harper. New York. 1958. Price $7.50.

The loom of history is the frame upon which the fabric of history is woven. As Muller sees this loom, it is made up of the ancient cities of Asia Minor. He discusses nine of them in detail in the body of his work, and 11 more in an appendix. The author is a professor of English and government. His work, therefore, is a very smooth piece of lively writing, and his primary interest is in the social structure that we have inherited from the ancient world he discusses.

Muller relates the saga of Asia Minor from the Hittites to the new republic of Kemal Ataturk. We owe far more to this small segment of the earth's surface than we are inclined to appreciate. The story of Troy was the beginning of Greek literature, history and theology. The cities of Ionia—birthplace of both philosophy and science—may have contributed more to our modern world than those of European Hellas. Saint Paul derived from Tarsus. Constantinople, Anatolian bridgehead across the Bosphorus, stood for a thousand years between Europe and eastern barbarism.

This vast, colorful story is told with insight and humor. "Congressmen and business men," says the author, "are generally indifferent to research unless it has practical useful objectives, such as colored television and hydrogen bombs." And, "Free thought or disbelief call for greater powers of mind than Constantine ever displayed; he was a half educated man, and seems to have been an essentially simple one."

This reviewer has not seen in a long time a historical work for general reading of greater interest or use, to the student of mankind, than *The Loom of History.*

Our Nuclear Adventure. By D. G. ARNOTT. 170 pages including index. Cloth. Philosophical Library. New York. 1958. Price $6.00.

This is a simplified exposition, for the general reader, of the problems of nuclear energy and the difficulties and threats in the modern world. Arnott outlines the general concepts of nuclear physics, their application in weapons of war, and particularly their application in developing peacetime energy. He feels that secrecy has often gone to absurd extremes, a point on which many nuclear physicists would agree; and he feels that the peoples possessing atomic power resources have lost popular control over them. International control, he thinks, must be preceded by control within the nations themselves, over their own activities. He sets forth as a goal the regaining by the common man of the control he once had over his own destiny. Since the discussion turns largely on this point, it is of unusual interest to social scientists.

Language in History. By HAROLD GOAD. 246 pages including index. Paper. Penguin. Baltimore. 1958. Price 85 cents.

The influence of history on language is something with which most of us, one supposes, have been long familiar. This book takes up the reverse —the influence of language on history. The author was a distinguished historian and teacher of languages; and the typescript for the present book was found in his effects when he died in Italy in 1956.

The thesis set forth here is that the form, the vocabulary and the flexibility of Latin—popular Latin in particular—had much to do with the rise, the organization and the eventual fall of the Roman Empire. Similarly, the Old French of the Crusades, spoken as a *lingua franca*, affected the entire history of Europe. Today, Goad finds the form and flexibility of English exerting similar influence on the world.

The semanticist and the psychiatrist will have no difficulty in following and developing this thesis. We have long known that emotional climate influences most speech and writing; that the converse should be true is also obvious enough. The discussion and the examples given here are most stimulating.

It may be a matter of some slight regret that the author did not pay closer attention to the speech of the United States and the role it plays —for Americans now make up the vast majority of those to whom English is the native tongue. Goad recognizes this and makes formal note of it. It is a pity that he was not familiar enough with American speech to treat its influence as adequately as—for instance—that of Elizabethan English.

An Atheist Manifesto. By JOSEPH LEWIS. 64 pages. Cloth. Freethought Press Assn. New York. 1956. Price $1.00.

An Atheist Manifesto is a much-advertised little primer which sets forth a very high standard of ethics, based on altruism, humanitarianism, refraining from knowingly inflicting avoidable pain on any living thing and dedication to freedom, scientific progress and the happiness of the human race. This is coupled with an all-out attack on Christianity, theology in general, and all religious beliefs and all religious establishments whatever. It concludes with a somewhat megalomaniacal offer by the author to stand between those who accept his beliefs and "the hosts of heaven" on the day of judgment.

The psychiatrist knows how often religious fanaticism can become entangled in the fabric of delusion, and the fanatism of atheism is no exception. This very short and very elementary treatise might be very useful in instances where atheism is adduced for the purpose of denying moral principles.

Love Camp. By LOUIS-CHARLES ROYER. 144 pages. Paper. Pyramid. New York. 1958. Price 35 cents.

How far the Germans actually got with the much-discussed project of love camps—human stud-farms to breed "Nordics"—this reviewer is not informed. There is no doubt, however, that it was seriously planned. Louis-Charles Royer's novel, translated from the French by Lawrence Blochman, is a story based on such a camp. The present printing is the fifth in five years by Pyramid Books. The story sells, of course, because it is sexy and sensational. It is, however, plausible and apparently sound psychologically. Royer perceives clearly the emotional disasters made inevitable by any such project; and this novel is worth at least some attention by anybody concerned with the probable consequences of handling human beings like farm animals, an idea by no means confined to Nazi Germany. This reviewer would be interested in either fictional or factual exposition of what the Nazis thought they were going to do with the children from these breeding places.

Man in Modern Fiction. By EDMUND FULLER. 171 pages including index. Cloth. Random House. New York. 1958. Price $3.50.

Edmund Fuller's book is a smooth and competent criticism of modern fiction from what he himself calls a minority point of view. He believes modern fiction is short of greatness because modern writers have lost the "Judeo-Christian and Hellenic traditions" in which there is a "basic view of man" as measured by the standards of right and wrong. In critiques of fiction ranging from James Joyce to James Gould Cozzens, Fuller finds the sense of right and wrong, and the consequent moral dilemmas facing man, to be generally lacking in contemporary literature. He holds that "we have a need and an obligation to re-appraise and re-focus our vision of ourselves and our species in terms of the great tradition of man which has shaped the constructive history of our western world." This is a book to inspire thought even among those who disagree with it most emphatically.

Studying and Learning. By MAX MEENES. 68 pages. Paper. Doubleday. New York. 1954. Price 95 cents.

The topic of this "Doubleday Paper in Psychology" is the application of certain basic principles of learning to the formulation of good habits of study. It is geared to the needs of the college student, and is a "how-to-do-it" paper which provides many valuable aids for the student. The author discusses: the effect of fatigue, anxiety, cramming, distractions, learning to study, proper budgeting of time, preparation of papers, the value of outlining and underlining, and many kindred subjects.

This serviceable little volume should be of particular interest to the student counselor as well as to the student himself.

Social Class and Mental Illness. By A. B. Hollingshead and F. C. Redlich. 423 pages. Cloth. Wiley. New York. 1958. Price $7.50.

One danger in a co-operative study between a sociologist and psychiatrist lies in the possibility that the more vocal sociologist will impose his views on a too-obliging psychiatrist. This appears to have happened in the present study, which aims to prove that there is a definite connection between social class and mental illness.

The authors use a series of objectionable devices: First, the term "class" is unsuitable, having out-dated Marxist connotations; what the authors obviously mean is the banality that every society has its prejudices, biases, differences in intelligence, income, and aspirations. Second, the authors' "five classes" are established according to purely sociological principles, a procedure unacceptable psychiatrically—it is difficult to see why the psychiatric co-author consented. Third, the investigation of treated patients is strictly limited, covering only half a year, and only patients in New Haven, Conn.

Other objections pile up: "Neither our data nor our inclination lead us to question the assumption that unconscious mechanisms may be common to all classes. Nor do we doubt that psychogenic developmental elements such as identification, oedipal conflicts, sibling rivalry, and psychosexual developmental patterns are basic to people in all classes... Recent research indicates that there are no differences in anxiety from class to class." One should note the restrictive "may," and the paucity of psychiatrically elucidated mechanisms. Self-damaging (pre-Oedipally-based) tendencies are not mentioned; and, since these can attach themselves to any external situation (class or no class) and so impair mental health, the idea that mental illness can be connected to social class appears to this reviewer to be untenable at the outset. There are other serious objections to this book from the psychiatric viewpoint. The text contains unjustified attacks on the social consciousness of psychiatrists; it also inclues rather naïve attempts to clarify the reasons as to why some physicians become psychoanalysts.

As a minor point, suggesting how dubious small samples are, one should mention the authors' statement that "some 64 percent of the analysts contracted mixed religious marriages." Obviously, New Haven is not typical. The reviewer thinks the value of this book is as a warning to psychiatrists not to collaborate in this sort of thing.

Thin Ice. By Sir Compton Mackenzie. 224 pages. Cloth. Putnam's Sons. New York. 1957. Price $3.50.

The life story of a highly intelligent and cultured homosexual is written with great delicacy, sympathy and illumination by his friend. It is an interesting and sensitive book.

Snakes in Fact and Fiction. By JAMES A. OLIVER. 199 pages with illustrations and index. Cloth. Macmillan. New York. 1958. Price $4.95.

Dr. Oliver succeeded Raymond Ditmars as curator of reptiles at the Bronx Zoo. In the present volume he presents material, for general reading, on the natural history of snakes with particular reference to their capture, transportation and maintenance at the zoo. His book concerns "fact" far more than "fiction." It omits discussion of the symbolism of the snake and contains comparatively little on snake folklore. Oliver does note that snakes are deaf and thus cannot be charmed by music, and he devotes considerable space to the discussion of the American Indian snake dances and other rituals involving the handling of poisonous snakes. The rattlers of the Hopi snake dance are, he believes, made harmless at the present time by removal of their fangs. He finds this practice in many parts of the world but suggests that in the Hopi dance it may be comparatively recent. (Incidentally, it eventually kills the snakes cruelly.)

This book is of considerably general interest but does not emphasize the aspects of the subject that are of particular concern to the social dynamic psychologist.

Psychical Research Today. By D. J. WEST. 144 pages including index. Cloth. Macmillan. New York. 1954. Price $2.50.

This book is a sober and scientific review of what is known about ESP. The author is a medical man and is not over-credulous. He reviews concisely but competently ESP material, ranging from Spiritualism and poltergeists to Rhine's experiments at Duke. A special investigator of the Society for Psychical Research, he is both well informed and skeptical. He believes that there is "some measure of certainty about a few basic facts" in psychical research, and deplores the difficulty of obtaining enough trained experimenters and persuading them to give enough time for serious work in the field.

The Origin of Species. By CHARLES DARWIN. 479 pages. Paper. Mentor. New American Library. New York. 1958. Price 50 cents.

The Origin of Species, of course, belongs in every general scientific library and in every library of the social and biological sciences in particular. One may or may not agree with Ashley Montagu that next to the Bible "no work has been quite as influential, in virtually every aspect of human thought," as Darwin's classic. But that it is the basis of modern biological science, nobody can doubt. The Mentor edition is nicely printed on reasonably good paper with clear type. At 50 cents, any student should be able to afford it.

The Slow Learner: Some Educational Principles and Policies. By M. F. CLEUGH. 186 pages with index. Cloth. Philosophical Library. New York. 1957. Price $3.75.

The slow learner is a problem for the teacher in a school that is supposedly made up of children of at least average intelligence. Either the teacher devotes too much time to the slow ones in the class, to the neglect of the others, or the teacher ignores the slow learners, with the result that they do not learn anything. Of course, the ideal answer is separate schools for those with below-average intelligence.

This book describes how this problem may be handled either by the establishment of special schools or by providing special educational treatment in ordinary schools. It also deals with the criteria for the selection of children for these special schools or classes, a very difficult problem when facilities are limited and the need so great. The last chapter deals briefly with the training of teachers who are going to teach the slow learners.

A Different Drummer. By ROBERT H. WELKER. 404 pages. Cloth. Beacon. Boston. 1958. Price $5.95.

Welker is a still comparatively young teacher of the humanities who sets down in this volume his bitter rebellion against a world he never made. Much of it is concerned with World War II and with the failure of America to realize that the "great hope" we can give the world is by support of world unity. Welker admired Roosevelt without adulation. He appears to have favored Wallace and to have had little use for Truman. He is sarcastic about Eisenhower. This summary of views is an approximation; it is rather difficult to tell precisely what Welker does mean. Only his pessimism and bitterness are set forth in no uncertain terms. They do not differ much from the reactions of millions of others, except that the author is articulate. This seems hardly reason enough, however, for writing or publishing this book.

The First Interview With A Psychiatrist. By CHARLES BERG, M.D. 240 pages with index. Cloth. Macmillan. New York. 1956. Price $4.25.

This is a book that should prove of value to anyone who must interview others and, to a very limited extent, to those who must be interviewed. The book is written by an analyst and therefore, is oriented toward unconscious motivation and psychosexuality. There are five parts. Part one deals with the interview, and Part two with the interviewer. Case histories demonstrating many psychodynamic factors are discussed in Part three. Part four is concerned with sexual immaturity and the sexual perversions. In Part five, the unconscious basis of the interview is discussed.

Music in Primitive Culture. By BRUNO NETTL. 182 pages. Cloth. Harvard University Press. Cambridge. 1956. Price $5.00.

Ethnomusicology is a science that deals with the music of peoples outside of Western civilization. The chief merit of Mr. Nettl's work in this discipline consists in his attempts to analyze the characteristics of primitive music according to such criteria as scale, melody, rhythm, form, polyphony, and types of musical instruments used. Unfortunately, the book is written in a rather uninspiring fashion, devoid of the illustrations that might enliven it. Only a person with a rather good technical knowledge of music could follow much of the discussion, which covers the philosophy, history and theory of primitive music in a sizable part of the volume. Mr. Nettl has apparently done considerable research, and recording of much music in the field. The scholarship and factual basis of this work is, therefore, undoubtedly sound. But surely there must be a way of making this subject more interesting to readers of the Western world who are curious about music so strange to their ears.

The Face of Justice. By CARYL CHESSMAN. 271 pages. Cloth. Prentice-Hall. New York. 1957. Price $3.95.

The author, condemned to death and living in the shadow of California's gas chamber for nearly nine years, presents the third volume of his trilogy, the previous volumes being bestsellers, *Cell* 2455 *Death Row* and *Trial By Ordeal*. He claims that he is not guilty of having transgressed the "Little Lindbergh Law," and that the transcript of his trial was falsified. It is impossible for the reader to determine Chessman's guilt or innocence; but he is confronted with an emotional appeal against the death penalty, and at that point he can have an opinion. It is rather ironical that an effective argument against the death penalty should come from a pathological individual, convicted of 16 charges. Chessman's strange book can well be read as an adjunct to Arthur Koestler's *Reflections on Hanging*.

Modern Sex Life. By E. W. HIRSCH. 160 pages. Paper. Signet. New York. 1957. Price 35 cents.

This book on sex rejects practically all unconscious factors and displays anger against psychiatry. Its author, a Chicago urologist, not only believes there is no vaginal orgasm, but that pleasure for the woman in intercourse is brought about by friction between penis and clitoris, described in terms to suggest contortions or deformity. He considers homosexuality at least partially biologically based, ascribes all faulty and neurotic sexual attitudes to stupid education, and thinks Kinsey a "genius" who deserves a "place among the immortals." A piece of prize advice to this book's general readers is to read "erotic verse" to "inflame the passions" of a frigid "bride," with the "Song of Solomon" specifically suggested.

Alphabets and Birthdays. By GERTRUDE STEIN. 238 pages. Cloth. Yale University Press. New Haven. 1957. Price $5.00.

In *The Reader's Encyclopedia*, William Rose Benet gives this description of Gertrude Stein's literary personality:

"Her unique and celebrated style . . . is characterized by a use of words for their associations and their sound rather than solely for their literal meaning, an intricate system of repetition and variation on a single verbal theme, an avoidance of conventional punctuation and syntax, an emphasis on the presentation of impressions and a particular state of mind rather than the telling of a story, and concreteness and extreme simplicity in diction, with preference for the commonplace and the monosyllabic . . . John Chamberlain once remarked that 'Steinese' style is like 'the Chinese water torture; it never stops and is always the same.'"

Benet does not mention that one can read pages or chapters of such a book without knowing what it is all about. The book reviewed here purports to be a children's book for adults; it is totally incomprehensible. As to style, here is a sample:

"On December the seventh she lost a newspaper
December the eighth were as nearly.
December the ninth when as soon.
December the tenth when as soon.
December the eleventh where as nearly.
December on the twelfth of December where and when.
On the thirteenth of December where and when as
nearly as soon.
On the fourteenth of December and to remember it
nearly as soon.

But Chamberlain's dictum, quoted by Benet, certainly exaggerates: There is no need for torture; one can put the book aside with a shrug of the shoulders.

Values in a Universe of Chance. Selected writings of Charles S. Peirce. Ph. P. WIENER, editor. 432 pages. Cloth. Stanford University Press. Stanford, California. 1958. Price $3.95.

Charles S. Peirce, philosopher and the father of pragmaticism, died in 1914. The present volume is a collection of some of his writings, and the interesting introduction by Wiener gives a series of not generally known biographical facts.

A Dialectic of Morals. By MORTIMER J. ADLER. 117 pages. Cloth. Frederick Ungar. New York. 1958. Price $3.50.

The author, best known for his instrumentality in establishing the "Great Books Program," attempts a geneology of morals—with inadequate means. He hardly takes the unconscious into consideration.

Mad for Keeps. With an introduction by ERNIE KOVACS. 128 pages. Cloth. Crown. New York. 1958. Price $2.95.

Back in the 1920's a magazine called *Ballyhoo* reached enormous, if short-lived, popularity by poking more than raucous fun at American advertising, American reading habits and similar activities. *Mad* is the mid-century version of the *Ballyhoo* spirit—neatly compiled of cartoon sadism and masochism, with matching text. It is equally raucous and even more slapstick.

The present volume is a selection of the best of *Mad* for those who want this sort of thing "for keeps." It takes flings at advertising, television, do-it-yourself, the film magazines, the "confidential" magazines and, above all, at the so-called comics. *Mad for Keeps* would be good reception-room literature for the doctor who has a good percentage of adolescent patients or of not over-mature adult patients, particularly if they are likely to appreciate allopathic doses of sadomasochism.

Encyclopaedia of Religion and Religions. By E. ROYSTON PIKE. 406 pages. Paper. Meridian. New York. 1958. Price $1.95. (Limited hard-bound edition: $5.95.)

Encyclopaedia of Religion and Religions should be a useful reference volume in any library of the social sciences and should be of considerable use as well to the practitioner of medicine who draws patients from areas where many faiths meet and mingle. It is made up of numerous short articles, some little more than definitions, covering the current Christian and Jewish sects, the Oriental religions and the principal religions of the ancient world. The author has compiled his book with enormous erudition and vast care. There are, of course, despite the greatest care, articles to which exception should be taken. For instance, to describe Zen as "an atheistic school" of Buddhism is highly debatable, if not altogether wrong. If, however, the reader remembers that no compilation of this sort can be without error, he should find the book very useful, and for the most part trustworthy.

Psychiatric Nursing. Syllabus and Workbook for Student Nurses. Second edition. By LENORE KIMBALL, B.S., R.N. 186 pages. Paper. Mosby. St. Louis. 1958. Price $3.00.

From a psychiatrist's point of view, this is an excellent manual for the student nurse. Without simplifying to a meaningless point, the author is able to make herself clear. The nurse-patient relationship is emphasized. How the patient feels about and how he reacts to his illness is stressed, rather than descriptive features. A set of problem-solving sheets and a personality study work sheet accompany the description of each emotional illness.

Israel and Problems of Identity. By MARGARET MEAD. 27 pages. Herzl Institute Pamphlets 3. The Jewish Agency for Palestine. 205 West 57th Street, New York 19, N.Y. Price not stated.

This is as important a communication as this reviewer has ever seen in such small compass. On the strength of a very short visit to Palestine, the author does not set herself up as adviser to the new nation of Israel or its English-speaking supporters; but she does derive material for an impressive illustration of how a world-wide problem is being solved on a small scale in a small country. The Israeli, she comments, are composed of peoples drawn from all the great races, white, black and yellow, and from cultures as diverse as the primitive village in the Atlas Mountains and the ultrasophisticated scientific circles of university life in Vienna. The vast problems of this diversity, she notes, are being solved by a common life for a common purpose. Identity is a key here; the Israeli are learning to identify positively—as something that they are, not as the negative of something they are not. The author urges that more studies be made of this process, and that they be made promptly: "Things are happening ... very fast ... and we're letting priceless material disappear because it isn't being studied."

Beyond My Worth. By LILLIAN ROTH. 317 pages. Cloth. Frederick Fell. New York. 1958. Price $3.95.

In this, her second book, the author writes with frankness and honesty of her continuing struggle to find peace and happiness within herself. Considerably less lurid than her first one, *I'll Cry Tomorrow*, the story of her fight against alcoholism, this is of equal interest psychologically. Placed too soon upon a pedestal, and with people on all sides turning to her for help, Miss Roth is nearly overcome with despair. Hysterical blindness is one of the results. Doubts about creed and dogma of the Roman Catholic Church, to which she is a convert, also plague her. Gradually, however, as she gains insight into her problems, and those of others, she achieves, not only success in her career, but also in her private life, a very personal triumph. *Beyond My Worth* is an instructive and most readable book, recommended for all.

A Dangerous Innocence. By VICTORIA LINCOLN. 310 pages. Cloth. Rinehart. New York. 1958. Price $3.75.

This is a psychological novel with a historical background—the nightmare time of witch-hunting in seventeenth-century Salem. But it is not essentially a historical novel, as we generally use the term, for it is the story, not of a period or place, but rather of a small group of people and their relationships to each other. The author's understanding of character is excellent; the growth in character of her young heroine in particular, is a poignant and moving piece of writing.

Masochism in Modern Man. By THEODOR REIK. 439 pages including index. Paper. Grove Press. New York. 1957. Price $1.95.

This paperback reprint is a very thorough discussion of masochism. It begins with a discussion of Freud's views. Reik essentially agrees with Freud's idea that masochism is "an offshoot of the death urge which has been libidinously bound." However, Reik feels that this is only a beginning of the study of masochism, although a very erudite one. Furthermore, he does not believe with Freud that masochism is derived "directly from sadism by a facing about against the ego." Rather, Reik believes that masochism "springs from the denial that meets the sadistic instinctual impulse and it develops from the sadistic, aggressive, or defiant phantasy which replaces reality." The book discusses the phenomena, dynamics, origin, ego-gains, social forms and cultural aspects of masochism. At times, the train of thought and theories are difficult to follow; but nevertheless, the book is an important contribution.

The Psychology of Sexual Emotion. By VERNON W. GRANT. 237 pages. Cloth. Longmans, Green. New York. 1957. Price $4.75.

The head of the department of psychology, Hawthornden State Hospital, Macedonia, Ohio, attempts in this volume to explain the problem of tender (not-sexual) emotions in love. Eclectically, he compiles and comments on excerpts from the scientific literature. He does not seem to be familiar with the newer psychoanalytic theories on the topic, nor in this reviewer's opinion, does he understand the problem of neurotic distortions, for example, his subchapter on homosexuality is amazingly uninformed.

Literary Essays. By DAVID DAICHES. 225 pages. Cloth. Philosophical Library. New York. 1957. Price $4.75.

A Cambridge professor's collection of 12 essays is written as if recent psychiatric contributions to literary criticism did not exist. An attempt at explaining "Walt Whitman's Philosophy" is obviously impossible without putting the fact of his homosexuality in the center, and it is not even mentioned. Or, the problem of "Guilt and Justice in Shakespeare" remains—to use an understatement—incomplete without taking the sonnets into consideration.

Ruby McCollum. Woman in the Suwanee Jail. By WILLIAM BRADFORD HUIE. 249 pages. Cloth. Dutton. New York. 1956. Price $3.95.

A very interesting, true account is given of the writer's involvement in a sensatiinal murder trial in west Florida. The author wanted, at first, only to interview in jail the Negro woman who had murdered her white doctor-lover. Denied permission to see her, he remained to argue with the court and meanwhile learned some revealing facts about Ruby, the doctor and Southern justice.

Home Health Emergencies. A Guide to Home Nursing and First Aid in Family Health Emergencies. By GRANVILLE W. LARIMORE, M.D., M.P.H. (revised) 256 pages. Paper. The Equitable Life Assurance Society of the United States. New York. 1956. Price free.

This paper-back book is a compilation of 48 pages devoted to "Home Nursing" and 208 to "First Aid." The section on nursing is a survey of hints, facts, methods and procedures and is meant for thorough reading. The second section is thumb-indexed alphabetically and is to be used both as a full study work and as a reference work. A table of poisons is given. It is thorough, covering most of the plausible home emergencies. Two pages are devoted to the emotional needs of the patient. The fear of the unknown is mentioned and the need for an honest attitude is stressed, especially in dealing with child patients, subjected to strange and painful procedures.

The book is free to anyone writing to The Equitable Assurance Society, 393 Seventh Avenue, New York 1, N. Y.

Suggestive Therapeutics. By H. BERNHEIM, M.D. Translated by CHRISTIAN A. HERTER, M.D. 420 pages including index. Cloth. Associated Booksellers. Westport, Conn. 1957. Price $5.95.

This is a translation of the second edition of a book written in 1887 by one of the pioneers in hypnosis and its use in mental illnesses. Although it was written 80 years ago, it is still one of the best reference books on the subject. It deals, in Part I, with the method employed in inducing hypnosis and the different manifestations which may be observed in hypnotized subjects. Part II discusses the history and the theory of hypnosis and its applications in psychology, legal medicine and sociology.

Helmet For My Pillow. By ROBERT LECKIE. 312 pages. Cloth. Random House. New York. 1957. Price $3.95.

This book is based on the war experiences of the author while serving in the marines in World War II. It is not the best book that has been written, but it is entertaining and humorous, although lacking in depth. The descriptions seem mechanical and dull, although this may be because so many readers are satiated with war stories and war memories.

The Age of Psychology. By ERNEST HAVEMANN. 107 pages. Cloth. Simon & Schuster. New York. 1957. Price $3.00.

An ambivalent book is authored by a journalist who wrote a series on the topic of psychology for *Life*. The *Life* articles are expanded in this small volume. The author is not uninformed, but he is not informed enough.

The Art of Loving: An Enquiry Into the Nature of Love. By ERICH FROMM. 133 pages. Cloth. Harper. New York. 1956. Price $2.75.

Fromm deals in this book with a problem that is as old as time: "How do we develop our capacity to love?" He warns the reader that this is no book for anyone who expects easy instruction in the art of loving. The book is divided essentially into three parts. The first is a definition of what love is and a description of various objects of love; the second part concerns the disintegration of love in western society; the third takes up the practice of love.

Fromm's main point appears to be that love is the answer to the problem of human existence; and, certainly, few would disagree, except possibly the Marxists. Yet the reader is left with the feeling that Fromm has not dealt as adequately with the conditions for the achievement of love as he promised in the foreword. In fairness one must say that no one, to the knowledge of the reviewer, ever has succeeded in Fromm's aims. He writes that "society must be organized in such a way that man's social loving nature is not separated from his social existence but becomes one with it." But to know how to organize society to achieve this aim, and how to implement the plan when it is framed, seem, as yet, unsolvable problems. However, by defining the problem and criticizing social conditions responsible for the absence of love, this book is a step in the right direction.

At times Fromm writes with the wisdom of Socrates—at other times naïvely. Why he feels it necessary to bolster his arguments by deliberately misinterpreting Freud to the reader is a puzzle to this reviewer. What else can one call it but deliberate misinterpretation when a scholar of Fromm's background writes, "according to Freud the full and uninhibited satisfaction of all instinctual desires would create mental health and happiness." Of course, when we stand on the shoulders of a giant, we like to kick him in the ribs occasionally, even when there is no justification for it.

There are other places where the reviewer feels that Fromm misinterpreted Freud. On page 58, Fromm writes "for him [Freud] self-love is the same as narcissism, the turning of the libido toward one's self." Freud's definition of narcissism shows that Freud did not regard self-love and narcissism as synonymous: "... in certain rare cases one observes that the ego takes itself as object and behaves as if it were in love with itself. For this reason we have borrowed the name 'narcissism' from the Greek Legend."* Of course, the key words are "as if it were."

On page 90, Fromm writes, "it [the Oceanic feeling] was interpreted by Freud (in *Civilization and its Discontents*) as a pathological phenomenon, as a regression to a state of early limitless narcissism." Fromm again is putting words in Freud's mouth. Freud did not say that the "Oceanic

*Freud, Sigmund: New Introductory Lectures on Psychoanalysis. Translated by W. L. H. Sprott.

feeling" was pathological. He wrote that he supposed that this feeling "seeks to reinstate narcissism." This does not imply that the "Oceanic feeling" is any more pathological than the feeling of hunger, which seeks to reinstate satiation.

Understanding Girls. By CLARENCE G. MOSER. 252 pages. Cloth. Association Press. New York. 1957. Price $3.50.

Understanding Girls is written with deep understanding. The author obviously is sincerely interested in the problems of the growing girl and has presented them in an easy-flowing style which makes very pleasant, informative reading. He deals with the subject from the child's viewpoint but always shows how the parents and the rest of the family are involved and how they can help—as well as what part the community plays in helping growing girls to reach maturity.

This is an excellent book for all parents, school teachers, club leaders and anyone else interested in today's youth. The author introduces his book with a chapter on the cultural patterns of today's home and community, saying the understanding of these is very important. The next chapter deals with the feminine role in our culture today. This is equally important for a basic understanding of the part home and community must play in helping girls grow wisely and happily. The ages covered are from six to 17; and, when reading this book, one is deeply impressed with the tremendous amount a growing girl must learn in these few short years.

A Father and His Fate. By IVY COMPTON-BURNETT. 207 pages. Cloth. Messner. New York. 1958. Price $3.50.

With a canvas only the size of a small family circle, with no description or explanation, by the sole means of conversation, the author creates a starkly tragic situation. One by one, the hypocrisy and self-deception of the characters are revealed, sometimes in a single line. Psychologically the book should be of interest, and from the point of view of writing, it is a brilliant job, and a unique one.

General Techniques of Hypnotism. By ANDRÈ M. WEITZENHOFFER, Ph.D. 460 pages with index. Cloth. Grune & Stratton. New York. 1957. Price $11.50.

This is an excellent book on hypnotism. It could be used to further the knowledge and techniques of the beginner or the advanced student; the lessons and plan of study are easy to follow. The book is divided into four parts. Part I gives general information about hypnosis and discusses the dynamics of hypnotism. Working suggestions are taken up in Part II, hypnosis and hypnotic suggestions in Part III. Part IV is the bibliography and the author and subject index.

A Hundred Years of Evolution. By G. S. CARTER. 206 pages including index. Cloth. Macmillan. New York. 1957. Price $3.75.

This is a short scientific history which it might be wished could serve as a model for a modern history of psychiatry. Carter traces the idea of evolution in its pre-Darwinian days, through the demonstration by Darwin and Wallace of its principal mechanism, down to present-day views. The work is carefully done and the material is well selected for the reading of persons who have not specialized in the subject. The author explains that he intends it both for the layman and for the biologist who is not primarily interested in the theory of evolution. To the non-specialist this work seems objective and well presented, if it proceeds somewhat ploddingly at times. It can be recommended safely for any scientific library not specifically designed for specialists in the subject.

Measurement and Evaluation in Psychology and Education. By ROBERT L. THORNDIKE and ELIZABETH HAGEN. 575 pages. Cloth. Wiley. New York. 1955. Price $5.50.

Written primarily as a text for introductory courses in educational and psychological measurement, the present work combines a lucid, succinct and well-organized exposition with a firm grasp of the essential concepts, techniques and utility of a wide but carefully selected and representive collection of tests. The emphasis throughout is on proper selection and utilization of tests with respect to the kind of information wanted. A necessary introduction to elementary statistical concepts and interpretation is provided. In general, this is an excellent introductory text.

The Medical Interview: A Study of Clinically Significant Interpersonal Reactions. By AINSLIE MEARES, M.B., B.S., B. Agr. Sc., D.P.M. 117 pages including index. Cloth. Thomas. Springfield, Ill. 1957. Price $3.50.

This is a book that can be recommended to all doctors, or to anyone else who has to conduct interviews. It is well written. It is short and concise. It is full of good advice on what to do and what not to do during the interview.

Research in Affects. 186 pages. Cloth. In: Psychiatric Research Reports of the American Psychiatric Association. Washington. 1957. Price $2.00.

The eighth research report, containing papers presented at the Regional Research Conference, held under the joint auspices of the American Psychiatric Association and State University of New York, Upstate Medical Center, Syracuse, includes an interesting study on rumination. Moreover, three symposia are included: disorders of affects during childhood; communication and affects; and experimental studies on affects.

American Philosophers at Work. The Philosophic Scene in the United States. SIDNEY HOOK, editor. 512 pages. Cloth. Criterion Books. New York. 1956. Price $7.50.

Edited by Sidney Hook, *American Philosophers at Work* is devoted to the thoughts of 29 leading philosophers. Each has contributed an article on what he considers his most significant contribution to American thought in his particular field of interest. The result is an encyclopedic volume of American philosophy, organized into three sections: "Logic and Scientific Method," "Metaphysics and Theory of Knowledge," and "Ethics and Social Philosophy."

While the volume includes the work of such well-known philosophers as Max Black, Abraham Kaplan, Ernest Nagel, C. I. Lewis, Brand Blanshard, Rudolf Carnap, and C. J. Ducasse, there are serious omissions.

Certain of the statements in the individual articles appear, on critical analysis, to be founded less on fact than on opinion and feeling; and, accordingly, this is a book with some gaps. Yet, articles such as Kallen's "Of Humanistic Sources of Democracy," and Hartshorne's "Some Empty Thoughts on Important Truths: A Preface of Metaphysics," are sound and provocative.

The Case of Jim. One Long Play Record and an Annotated Script of the Record. Produced by JULIUS SEEMAN, Ph.D. Distributed by Educational Test Bureau. Nashville, Tennessee. 1957. Price $5.50 plus postage.

This record is made up of passages from psychotherapeutic sessions involving a young man in his early twenties and the therapist, Dr. Seeman. It is an excellent example of how psychotherapy may be conducted, and should be very useful for teaching purposes. Many of the mechanisms of defense can be demonstrated: there is a very real experience of abreaction; and the ways that suggestion, support and the creating of a non-threatening therapeutic situation are used, are also very instructive.

Most of the sound of the record is fair, but it is poor in spots. Apart from this, it is highly recommended.

Raising Demons. By SHIRLEY JACKSON. 310 pages. Cloth. Farrar, Straus and Cudahy. New York. 1957. Price $3.50.

Shirley Jackson's *Raising Demons* is a fast-moving novel of domestic reminiscences, written with wit and tenderness. Her tale of parental problems in raising four children is an affectionate effort in evaluating present-day family-rearing conditions. She writes with discernment, but at times repetitiously, of the increasing pressures of material possessions, animals, unwarranted acquisitions and her children in general. Most parents—and social workers, too—will find much to amuse them in this book.

CONTRIBUTORS TO THIS ISSUE

FRANZI WEISS, M.S.S. Mrs. Weiss was born and educated in Vienna, where she was trained to teach foreign languages and conduct nursery school; and she conducted a Vienna school until emigrating in 1939. After a stay in England, she came to the United States with her husband in 1940. She taught nursery school in Boston and New York City, then attended City College in New York City, from which she was graduated magna cum laude, with a bachelor's degree in education, in 1951. She was graduated in 1953 from the New York School of Social Work with the degree of master of social science, in social work. She had specialized in psychiatric studies. She has been engaged in social case work since, and has been with the New York State hospital system since 1954, first at Rockland State Hospital, then with the thorazine unit of the Manhattan Aftercare Clinic, then again at Rockland where she is now a senior psychiatric social worker.

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Dr. Overholser has been president of the American Psychiatric Association; he received the first Isaac Ray Award of that association; and has been the recipient of many other honors. He was head of the United States delegation to the International Congress of Mental Health, London, in 1948 and vice president of the World Congress of Psychiatry, Paris, in 1950. He has received decorations from France and Haiti. He is the author of numerous scientific articles and several books, and is editor in chief of the *Quarterly Review of Psychiatry and Neurology*. He has been particularly interested in forensic psychiatry and has devoted much writing to that subject.

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GEORGE M. LOTT, M.D. Dr. Lott has been psychiatrist and professor in the graduate school of Pennsylvania State University, where he has been training clinical psychologists, for the last 10 years. A graduate of the University of Michigan and of Colorado Medical School, he has held numerous positions in child guidance and psychiatry. He served as state psychiatrist and director of the Rhode Island Bureau of Child Guidance, was a school psychiatrist for the New York City schools and for six years worked in the field of prevention in the mental hygiene division of the Suffolk County (N.Y.) Board of Health. He is the author of numerous scientific articles and of a new book, *The Story of Human Emotions*.

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ROBERT BARRIE. Mr. Barrie is executive director of the New York Society for Mental Health. He is a graduate of New York University and of the New York School of Social Work. Except for service during the war, he held positions in national, state and local tuberculosis associations from 1938 until he took his present position in 1955. Mr. Barrie is married, lives in Yonkers and has three children.

ABE J. JUDSON, Ph.D. Dr. Judson received his A.B. and M.A. degrees from George Washington University, and his Ph.D. from the University of Maryland in 1950. Since that time he has been teaching psychology at Utica College. Recently he has been engaged in research on the effects of chlorpromazine on psychological test scores, at Marcy (N.Y.) State Hospital.

ERNEST HARMS, Ph.D. Dr. Harms, born in Alsfeld, Germany in 1895, planned to become a psychiatrist, took a pre-medical course at Marburg University and studied with Emil Kraepelin in Munich. He says that he followed "the trend of the time" in believing that academic psychiatry had an unsatisfactory scientific basis, turned to the study of psychology, and received his Ph.D. in psychology in 1919 from Würzburg University. He studied briefly with Freud in Vienna, then went to the Zurich School of Psychiatry for graduate work and later to Paris for study with Pierre

Janet. He also studied in England where he met William McDougall and Mary Calkins and was invited to come to the United States where he was a fellow at Harvard and at Duke universities for about two years.

Returning to Europe, he was a founder and director of the *"Internationale Väklerpsychologische Institut."* He taught in Estonia, Denmark and Finland, and also engaged in editorial work. The institute was closed in 1933 because of the rise of Hitler. Dr. Harms went to Switzerland for two years, then came to the United States again in 1936 on the invitation of Adolf Meyer. He has been in this country since that time. With the help of Alfred Adler, he went into private practice as a clinical psychologist in 1936 and later did much teaching and work in the field of mental abnormality in childhood. He founded the journal, *The Nervous Child,* with the collaboration of Ira S. Wile. He edited the *Journal of Child Psychiatry* later and the *Handbook of Child Guidance.* At present he is director of the Beth David Hospital child guidance clinic.

With his wife, he has maintained a children's camp for the last 14 summers in which, he states, there have been attempts to work out special techniques in mental health adjustment. He has recently been interested in research and writing on the history of psychiatry.

E. DAVID WILEY, LL.B. Mr. Wiley is associate attorney and head of the office of counsel of the New York State Department of Mental Hygiene, Albany. He has been in state service since 1937 and with the department since 1941. Born in Maine, he received his law degree from Albany Law School in 1936. He served during World War II in the office of general counsel for the Social Security Agency, on the Army Air Force Evaluation Board, and with the Office of Strategic Services. He is admitted to practice before the New York State and federal courts and is a member of the New York State and Albany County Bar Associations.

A. S. The initials, A. S., are those of a psychiatrist who has contributed previously to this journal, and prefers to have his present versified contribution appear over his initials only.

NEWS AND COMMENT

CRIMINAL INSANITY PROCEDURE STUDIED

Four psychiatrists and four members of the bench and bar were named by Governor Averell Harriman in December 1957 to inquire into New York State laws and procedures for dealing with the criminally insane. The committee will study problems resulting from the century-old McNaghten Rule which still governs criminal responsibility in New York State. The rule holds, in brief, that a person is responsible for his acts, if he is able to tell, regardless of other mental abnormalities, whether his acts are wrong or right at the time of committing them. The McNaghten Rule has been under criticism of psychiatrists for many years. The psychiatric members of the committee are David Abrahamsen, M.D., New York City; Richard V. Foster, M.D., assistant commissioner of the New York State Department of Mental Hygiene; Francis E. Shaw, M.D., director of Dannemora (N.Y.) State Hospital, and Christopher F. Terrence, M.D., director of Rochester (N.Y.) State Hospital.

GEORGE LAWTON, PH.D., PSYCHOLOGIST, DIES AT 57

George Lawton, Ph.D., widely known as a clinical psychologist and a writer, died of a heart attack at his home in New York City on October 8, 1957 at the age of 57. Dr. Lawton, who received his Ph.D. from Columbia University, had been a psychiatric social worker, a clinical psychologist, a writer and lecturer. He underwent heart surgery in 1954 and in January 1957 published a personal account of his feelings as a patient in *Straight to the Heart*. He was particularly interested in psychoanalysis, was a counselor on marital problems and had devoted much of his time in recent years to gerontology. He was the author of a number of other books and scientific articles, in addition to the one recounting his experience as a heart surgery patient.

RUSSIAN TRANSLATION PROJECT ANNOUNCED

Exclusive world-wide rights to translate and publish English-language editions of 20 Russian scientific and technical journals have been assigned to Consultants Bureau, Inc., a New York publishing concern, the firm has announced. Work ranging from biochemistry to astronomy is covered in the journals concerned. No strictly medical publications are included.

WORKSHOPS, CONFERENCES AND MEETINGS SCHEDULED

A workshop in projective methods for the study of personality is announced for June 23 to August 7, 1958 at the New School for Social Research in New York City. It will be under the direction of Florence R. Miale and Camilla Kemple, who have conducted the summer workshops at the New School since 1951.

The 1958 annual workshop in projective drawings will be conducted in New York City on August 4 to August 7 by Emanuel F. Hammer, Ph.D., and Selma Landisberg, M.A. Karen Machover will be guest lecturer. Information as to admission may be obtained from Miss Landisberg at 166 East 35th Street, New York 16, New York.

Medical Education Week for 1958 is from April 20 to 26 and the 1958 Mental Health Campaign is to cover the months of April and May.

The 1958 Conference on General Semantics will be in Mexico City from August 24 through August 27 at the invitation of Mexico City College.

The Fourth International Congress of Psychotherapy will be from September 1 to 7 in Barcelona. The main theme will be "Psychotherapy and Existential Analysis."

RABBI JOSHUA BLOCH DIES AT 67

Rabbi Joshua Bloch, chaplain in the New York State Department of Mental Hygiene and widely known as a writer and librarian, died of a heart attack at Creedmoor State Hospital, Queens Village, N. Y., where he had gone to preach a Rosh ha-Shanah service on September 27, 1957. He was 67 years old. Dr. Bloch retired in 1956 as chief of the New York Public Library Jewish division, which he had headed for 33 years.

STATE SCHOOL BOOKLET IS PUBLISHED

A booklet of 32 pages covering the care of mentally retarded children in state schools was made available by the New York State Department of Mental Hygiene in November 1957. It is entitled "A World to Grow In" and is intended for parents. It explains admission procedures and institution activities, including education, training and recreation. It is illustrated with photographs taken in the New York state schools. Single copies may be obtained without charge by addressing the Office of Mental Health Education and Information, Department of Mental Hygiene, 217 Lark Street, Albany, N. Y.

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